Fraser Health Authority Supervised Consumption Site Evaluation Plan

by

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Preface:

I am a graduate student in the Master of Public Health Program at Simon Fraser University. The Fraser Health Supervised Consumption Site Evaluation Plan will serve as my Capstone Project in completion of my MPH degree. From May-July 2016, I had the opportunity to complete my practicum with the Fraser Health Authority's Population and Public Health Department. I was fortunate to be asked to return to Fraser Health to complete my Capstone and assist with the evaluation plan for their supervised consumption sites.

The recent number of overdose deaths resulting from illicit drug use is a tragedy that has shaken our entire province. I am grateful to have had the opportunity to work alongside a team attempting to address this crisis and prevent future tragedies. I hope that this evaluation plan will help to reduce further loss in our communities.

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List of Acronyms:

BC	British Columbia
BCCDC	BC Centre for Disease Control
BIA	Business Improvement Association
DTES	Downtown Eastside
ED	Emergency Department
FH	Fraser Health
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MSIC	Medically Supervised Injecting Centre
OAT	Opioid Agonist Treatment
PWID	People who inject drugs
PWUD	People who use drugs
RCMP	Royal Canadian Mounted Police
SAC	Sobering and Assessment Centre
SAS	Statistical Analysis Software
SCS	Supervised consumption sites
SEOSI	Scientific Evaluation of Supervised Injecting
SIF	Supervised injection facilities
SMH	Surrey Memorial Hospital
THN	Take Home Naloxone

Executive Summary:

In 2016, British Columbia experienced a devastating number of illicit drug overdose deaths resulting in the declaration of a public health emergency. In light of this crisis, the Fraser Health Authority launched their Enhanced Overdose Response Strategy which included submitting applications to Health Canada for the operation of two supervised consumption sites in Surrey, British Columbia. While sometimes controversial, there is abundant research evidence in the literature supporting the effectiveness of supervised consumption sites in reducing overdose deaths and infectious disease risk behaviour, increasing referrals and entry to detoxification and addiction treatment programs, improving access for people who use drugs to medical treatment, fostering safer injection practices, decreasing drug-related public disorder and producing cost savings. Nevertheless, it is still paramount to critically evaluate both supervised consumption sites to understand the health and community impacts they are having in the Surrey community.

The purpose of this evaluation is to assess the impact and effectiveness of the supervised consumption sites being implemented by Fraser Health. A first step in any evaluation is to develop a comprehensive evaluation plan. The evaluation plan for Fraser Health Supervised Consumption Sites that follows has been created in consultation with several key stakeholders (Fraser Health, community partners, the City of Surrey, and the Royal Canadian Mounted Police) to ensure that the plan meets their objectives and needs. The evaluation will focus on three main questions:

1. Are the services being provided as intended at the two supervised consumption sites?
2. Are SCS services adapting to client and community needs?
3. Are the intended benefits of each supervised consumption site being recognized?

Each main evaluation question is accompanied by several sub-questions that will be assessed using specific indicators. Both the indicators and data collection strategies have been adapted from the methodology used in previous evaluations of existing supervised consumption facilities. Comparing the results from the current evaluation with previous evaluation findings allows for greater validity and reliability despite limited time and resources.

This evaluation is designed to be utilization-focused to ensure Fraser Health and other key stakeholders are able to use the findings to inform decision-making for the sites. Therefore, an evaluation matrix including indicators, data sources, data collection strategies, responsibilities, and timeframes will serve as a working document for the Fraser Health evaluation team and can be adapted as the evaluation progresses. A mixed methods approach will be used for data collection and analysis. Data collection will require cooperation among several groups of stakeholders and will be collected through an access database, surveys, key informant interviews, tracking tools, comment cards, and secondary data sources such as the City of Surrey and RCMP. Data analysis will be focused on addressing the evaluation questions, and the findings will be summarized in a detailed report to be shared with stakeholders. Finally, the findings will be disseminated through news releases, press conferences, community and stakeholder consultations, and on the Fraser Health website to ensure all stakeholders and the general public are aware of the impact of the supervised consumption sites.

1. Introduction to the Evaluation Plan

Surrey has experienced a dramatic increase in both fatal and non-fatal opioid-related overdoses, as has British Columbia (BC) as a whole. The overdose crisis in Surrey is complex and stems from decades of ineffective policies, increased impact of the broader social determinants of health (i.e. physician prescribing practices, homelessness, poverty), and the emergence of potent opioids such as fentanyl. Fraser Health (FH) recognizes that ideally all FH residents are free of substance use, are securely employed, are supported by families, and are stably housed. However, large numbers of individuals who are opioid dependent reside within FH, and with rates of relapse from abstinence treatment programs being as high as 60%, expecting people who use drugs (PWUD) to achieve abstinence is unrealistic even with the strongest community services and supports (van den Brink & Haasen, 2006). Therefore, FH has adopted a strategy with actions aimed at meeting the needs of PWUD regardless of which stage they are at along the prevention to recovery continuum.

As part of their strategy, FH has chosen to implement evidence based harm reduction interventions to help mitigate drug related harms in the Surrey community including Opioid Agonist Treatment (OAT) programs, enhanced naloxone distribution and training, increased distribution of sterile consumption equipment and needle collection, and supervised consumption services. The most controversial of these strategies is the implementation of two supervised consumption sites (SCS) in the city of Surrey, BC. Although evidence from SCS facilities in Vancouver, Australia, and Europe have demonstrated that SCS are effective at reducing drug related harms and improving public order, supervised consumption services continue to face tremendous opposition (Tyndall et al., 2007; Wood et al., 2004a). In addition, SCS in Canada are required to meet extensive criteria to receive an exemption under the Controlled Drugs and

Substances Act, before they can be implemented (Smith, 2015). In order to receive an exemption, FH is required to have the support of key stakeholders in the community and develop measures to address key stakeholder concerns. To address the concerns of relevant stakeholders, FH has committed to conducting a comprehensive evaluation that will include outcomes and metrics related to services provided (including outreach), health outcomes, and community impact. The plan for this evaluation is detailed in the report that follows and will provide the basis for all evaluation related activities for both FH SCS sites.

1.1 Purpose of the Evaluation

The purpose of this evaluation is to assess the impact and effectiveness of the SCS being implemented by FH in the city of Surrey. Evaluating the SCS is important for several reasons:

- First, the evaluation findings will provide evidence that will be important for SCS stakeholders. In SCS applications to Health Canada and in community consultations, FH committed to conducting an evaluation of each site. To ensure that FH is remaining accountable to stakeholders and the community about the impact of the SCS, obtaining objective measures of performance and disseminating the findings is crucial.
- Second, an evaluation will help determine if the SCS is offering the appropriate services and meeting client and community needs.
- Third, the evaluation will determine whether or not the intended benefits of the SCS are being achieved and will provide further evidence on the impact of supervised consumption services.

1.2 Intended use of the Evaluation

The results of this evaluation will be used to demonstrate the impact of SCS on outcomes of interest to various stakeholders. The evaluation will also be used to inform several process indicators that could lead to refinement or modification of site operation and policies. Finally, the evaluation will add to the existing evidence base regarding the effectiveness of SCS.

1.2.1 Primary Intended Users of the Evaluation

The primary intended users of this evaluation are FH Senior Executive Committee, the SCS implementation team (including representatives from FH Population and Public Health (PPH) and Mental Health and Substance Use (MHSU) departments), SCS staff, City of Surrey, Royal Canadian Mounted Police (RCMP), and the Surrey Business Improvement Association (BIA). The evaluation questions identified in this report have been established based on the interests of the primary intended users.

1.2.2 Secondary Intended Users of the Evaluation

The secondary intended users of this evaluation are the SCS clients, PWUD in the community, residents in the community, the Surrey School District, Ministry of Health, Health Canada, the BC Centre for Disease Control (BCCDC), Lookout Emergency Aid Society and other community partners. While the evaluation questions identified in this report may be of interest or have an impact on these groups, these stakeholders were not involved in structuring the evaluation. Therefore, these groups have been identified as secondary intended users.

1.3 Scope and Limitations

This evaluation is focused on examining only those evaluation questions most critical to the successful operation and intended outcomes of the sites. The evaluation has a narrowed focus because it is bounded by limited resources and time. Also, because sufficient evidence exists in the literature demonstrating the effectiveness and impact of SCS, and because new findings are unlikely to emerge at the FH sites, duplication of rigorous research studies from other facilities is unnecessary. Therefore, this evaluation will focus more on ensuring the interests and expectations of intended users are satisfied as opposed to adding to the abundant literature examining SCS.

Because the SCS primary goals do not involve adding to the scientific literature, the SCS will not be based upon a cohort of injection drug users such as the Scientific Evaluation of Supervised Injecting (SEOSI) cohort at Vancouver's supervised injection facility (SIF)[1], Insite. While Insite operated under an exemption from the Controlled Drug and Substances Act, its operation was contingent upon the construction of a rigorous evaluation, and the FH SCS will not face the same requirements (Boyd, 2013). The absence of a study cohort may affect the validity and reliability of the evaluation findings; nevertheless, the current evaluation has tried to replicate the methodology from evaluations of existing SCS wherever possible. As a result, most of the findings from the current evaluation will have the ability to be compared to existing evaluation research to ensure validity and reliability. Also, the evaluation will rely on secondary data from several sources to minimize resources in data collection and for triangulation of data.

[1] The terms supervised injection facilities (SIFs) and supervised consumption sites (SCS) are often used interchangeably. For the purposes of this report, SCS has been used to describe the FH sites. The BC Ministry of Health has requested that new consumption facilities be called "supervised consumption sites" to allow for alternative modes of administration (i.e. oral & intranasal administration). Existing SIFs such as Insite in Vancouver are limited to injection drug use and do not accommodate other routes of administration, while SCS will allow consumption of drugs orally or intranasally. By allowing drug users who consume drugs orally or intranasally to access the sites, SCS may be more accessible to the drug user population.

2. Program Profile

2.1 Organizational Context

The Fraser Health Authority is one of five regional health authorities in BC delivering prevention, hospital, residential, community-based and primary health care services. FH is the fastest growing health authority in B.C. serving over 1.8 million people. The region serviced by FH runs west to east from Burnaby to Hope and north to south from Boston Bar to the Canada/U.S. border. This geographic area, referred to as the Fraser Region, includes 16 municipalities across three health services delivery areas: Fraser North, Fraser East, and Fraser South. The Fraser Region is home to one of the most economically, culturally, and geographically diverse populations in B.C. including 40% of the province's immigrants and 38,100 First Nations people.

Fraser Health's mission is "to improve the health of the population and the quality of life of the people [they] serve." As a result, FH delivers a full continuum of health services, from broad population health programs to hospital-based services. These services are mainly delivered by FH physicians and staff in facilities throughout the Fraser Region; however, some FH services are contracted out and delivered through other providers. The department involved in FH's Overdose Prevention and Response Strategy including the implementation and operation of SCS are PPH and MHSU. Both programs work closely with internal and external stakeholders to provide public health and substance use programs and services to communities throughout the Fraser Region and are coordinating their efforts on the implementation of the SCS sites.

2.2 Program Background

To understand why FH is implementing two SCS facilities, it is important to discuss the harms that are associated with illicit drug consumption and the various approaches that have been used to minimize these harms.

2.2.1 Harms associated with illicit drug consumption

Illicit drug use is prevalent in Canada with 10.2% of people reporting using cannabis and 1.7% of people reporting using cocaine or crack, speed, ecstasy, hallucinogens (excluding salvia) and heroin (CADUMS, 2012; Health Canada, 2011). As well, abuse of psychoactive pharmaceutical drugs including opioid pain relievers, (such as Percodan, Demerol and OxyContin); stimulants, (such as Ritalin, Concerta, Adderall and Dexedrine); and tranquillizers and sedatives, (such as Valium, Ativan and Xanax) are reported by 0.7% of Canadians (Health Canada, 2011). Significant health consequences are associated with illicit drug use including non-fatal and fatal overdose, blood-borne viruses, and cutaneous infections.

Overdoses are a leading cause of morbidity and mortality among illicit drug users. The reported prevalence of non-fatal overdoses among PWUD ranges between 20% and 70% per lifetime depending on the region in Canada (Kerr et al., 2007a; Kinner et al., 2012; Silva et al., 2013). Although only a few provinces actively report drug related overdose deaths, coroners' reports from several Canadian provinces indicate that hundreds of overdose deaths occur each year (Canadian Drug Policy Coalition, 2012). Recently, the emergence of fentanyl has caused an alarming spike in overdose deaths (Socias & Ahamad, 2016). Coroners' reports from Canada's largest provinces indicate that the number of overdose deaths across Canada in 2016 could be in the thousands (Woo, 2016). For example, in 2016, 922 illicit drug related overdose deaths

occurred in BC alone –a 60% increase from 2015 (Coroner's Service Report, 2017; Russel, 2016). In the past few years, fentanyl has been detected in various street drugs across Canada and is popular among opioid users and drug dealers because of its potency (Jafari, Buxton, & Joe, 2015). Because the difference between an effective and fatal dose of fentanyl is very small, and because it is an unregulated substance in Canada with variable doses of the drug appearing in pill or powder form, fentanyl use is associated with a high risk of overdose death (Young, 2015). Also, fentanyl is often sold as fake OxyContin or heroin resulting in many drug users unknowingly exposing themselves to a more powerful opioid than expected (Young, 2015).

In addition to the risk of overdose, injection drug use is associated with several serious drug-related harms including transmission of blood-borne infections and injection site bacterial infections (Hunt, Trace, & Bewley-Taylor, 2005). Human immunodeficiency virus (HIV) and hepatitis C virus (HCV) are the most common blood-borne infections contracted by people who inject drugs (PWID) worldwide. In Canada, an estimated 15-20% of PWID have HIV, and PWID account for 12.8 % of reported HIV cases (Public Health Agency of Canada, 2010). Some estimates indicate PWID are approximately 59 times more likely to contract HIV than people who do not inject drugs (Degenhardt & Hall, 2012; Challacombe, 2017). Although advances in antiretroviral therapy have improved the survival and quality of life of HIV infected persons, HIV is still responsible for a significant number of deaths among PWID each year in Canada (Canadian HIV/AIDS Legal Network, 2005). HCV is even more prevalent among PWID in Canada, with an estimated 68% of injection drug users having or having had HCV in their lifetime (Challacombe, 2017). In addition to the life years lost from these diseases, HIV/AIDS and HCV cost the Canadian health care system millions of dollars (Bayoumi & Zaric, 2008). Finally, studies have shown that injection-related site bacterial and soft tissue infections

account for the majority of emergency room visits and hospitalizations among PWID in Canada (Kerr, 2004). Cutaneous infections such as cellulitis and abscesses are common infections among PWID and mainly result from unhygienic injection practices (Lloyd-Smith, 2005). Clearly, the health consequences associated with illicit drug use severely impact many PWUD and result in death, disease, and tremendous costs to the health care system.

2.2.2 Risk Factors associated with illicit drug consumption

PWUD are a high-risk group for overdose and infection as a result of various social determinants and individual characteristics. While most interventions focus on minimizing individual risk behaviours (such as educational interventions), it is important to recognize the limitations of these approaches. Risk behaviours associated with illicit drug use are often shaped by a constellation of forces beyond the control of individual drug users, resulting from interactions between broader social and structural environments (Rhodes, 1997). For instance, drug entrenched populations are often characterized by poor health, gender inequities, poverty, insufficient access to health care services, and a lack of housing and social supports that exacerbate health risks among PWUD (Fischer et al., 2004). Indeed, lack of stable housing and poverty results in many PWUD consuming substances in public settings where exposure to police and other drug users can increase the risks associated with drug use (Small et al., 2007).

Rhode's (2002) "risk environment" framework has improved the understanding of how various social and environmental factors influence the risk of individuals experiencing drug related harm, as well as the impact of interventions that aim to minimize these harms. This research on the social context and physical environment of injection drug use suggests that drug consumption settings either facilitate safer consumption practices or limit such practices by

shaping individual ability to enact risk reduction measures (Rhodes, 2002). Specifically, the risk of drug related harm in settings is often determined by the availability of sterile syringes and the ability to practice safe consumption techniques without disruption (Singer et al., 2000; Rhodes et al., 2006). Research from the downtown eastside (DTES) of Vancouver indicates that injection drug users will partake in risky injection behaviour to protect themselves (and their drugs) from disruptions such as arrests or assaults in unregulated settings (Kerr, Small, & Wood, 2005a). As a result, SCS act as an important intervention to minimize disruption to promote safe consumption practices, decrease the likelihood of police or public interference, and reduce the need for rushed drug consumption (Rhodes et al., 2006). Also, the supervision provided by health professionals at the sites further mitigates the risk of unsafe injection practices and overdose deaths. SCS have the common goal of improving access to sterile drug consumption equipment, hygienic consumption environments, sterile water, and adequate lighting. These consumption services are often complemented by individual-focused educational and behavioural health interventions to help encourage safer consumption practices and encourage entry into addiction treatment programs (Rhodes et al., 2005).

Indeed, evidence from safer injection sites such as Insite indicates that frequent SIF users are less likely to rush and share syringes than less frequent SIF users (Stoltz et al., 2007). Moreover, consistent Insite users are more likely to use sterile water, swab injection sites, safely dispose of syringes, and cook or filter their drugs. Therefore, SCS can help minimize major risk factors associated with HIV and HCV such as blood-to-blood contact that occurs when sharing contaminated syringes or other contaminated drug-use paraphernalia (Hunt et al., 2005). As needle sharing is prevalent among drug users in Canada (Fischer et al., 1999; Wood et al., 2001), additional community interventions such as needle-exchange programs or distribution of safe

consumption equipment can also help reduce the risk of infection (Canadian HIV/AIDS Legal Network, 2005).

By reducing high-risk injection behaviours such as injecting alone, needle sharing, and rushed injecting, SCS also reduce the risk of fatal overdoses. Clearly, shifting the injection setting to an SCS where health professionals monitor PWUD results in more immediate, life-saving intervention (using oxygen or naloxone) in the event of an opioid overdose. However, many individual risk factors still place PWUD at a high risk of overdose even if they have access to an SCS. Individual characteristics such as drug use frequency, duration, main drug consumed, poly-drug use, and concurrent alcohol use can all influence a person's risk of overdose (Fischer et al., 2004). Also, people who use illicit substances with greater unpredictability in drug purity or formulations are more likely to experience overdose (Canadian HIV/AIDS Legal Network, 2005). For instance, the high potency of fentanyl and the frequency with which it is used to adulterate or cut other drugs results in tremendous overdose risk. Finally, research has shown that non-fatal overdose events are independently associated with subsequent fatal overdoses (Caudarella et al., 2015). These findings suggest that those individuals who engage in high-risk drug behaviours or who have experienced a non-fatal overdose should be targeted for overdose prevention interventions such as substitution therapies, drug treatment programs, and educational interventions.

2.2.3 Harm Reduction in Canada

Harm reduction oriented programs are becoming more common in Canada to address health harms stemming from injection drug use. Harm reduction as a social policy is relatively new in Canada, but is gaining more traction as opposed to the abstentionist or "zero tolerance"

policies towards drug use that have traditionally been used (Inciardi & Harrison, 2000). The goal of a harm reduction approach is to reduce the adverse consequences of drug use among PWUD without requiring abstinence from drug use (Single, 1995). Therefore, harm reduction strategies attempt to reduce the potential for drug related health harms and the likelihood that PWUD will overdose, contract HIV, HCV or experience other adverse health issues. Ultimately, these strategies provide support and resources for PWUD that can help address extra-individual factors driving drug-related harm including housing, poverty, and access to health and social services (Inciardi & Harrison, 2000).

Canada has increasingly adopted harm reduction strategies to address substance use recognizing the limitations and unintended consequences stemming from drug prohibition and the criminalization of drug use. These harm reduction strategies are evidence-based and include addiction treatment (not requiring abstinence), needle-exchange programs or provision of sterile injection equipment, safe injection education, overdose prevention education and response training, and supervised consumption services (Canadian HIV/AIDS Legal Network, 2005). Among harm reduction strategies adopted in Canada, the most controversial and widely debated are SCS.

Although SCS have been successfully implemented across Europe, Australia, and North America, opposition in Canada has been strong with claims that such sites encourage drug use, nuisance, and disorder (Boyd, 2013). Nevertheless, studies evaluating SCS refute these claims documenting decreased public injecting behaviour and drug-related public disorder (Kerr et al., 2006). Moreover, SCS have proven to be one of the most effective harm reduction strategies in reducing drug related harm and improving social integration among PWUD (Canadian HIV/AIDS Legal Network, 2005).

2.2.4 History of Supervised Consumption Services

The first SCS emerged in Europe with a facility opening in the Netherlands in the early 1970s (Dolan et al., 2000). Similar sites in Switzerland and Germany followed throughout the 1980s and 90s and by 2009, there were ninety-two SCS operating in sixty-one European cities (Hedrich et al., 2010). In 2001, a site opened in Sydney, Australia called the Medically Supervised Injecting Centre (MSIC) after the King's Cross area had experienced a disproportionate number of drug overdoses (Uniting, n.d.). Finally in 2003, Insite opened in the DTES of Vancouver[1] and became the first SIF in North America. Insite was created in response to a spike in HIV infections and deaths from illicit drug use in the DTES of Vancouver in the 1990s (Kerr, Oleson, Tyndall, Montaner, & Wood, 2005b).

Both MSIC and Insite were highly controversial pilot studies that were granted legal exemptions by their respective governments. However, these exemptions were contingent on the generation of scientific evidence pertaining to the operation and impact of the facilities (Boyd, 2013). Therefore, both SIFs were required to conduct rigorous evaluations in order to continue receiving approval for the operation of the sites. These evaluations have significantly contributed to the body of knowledge about SCS (Boyd, 2013). Although European SCS faced opposition, most sites operated legally alongside other service networks (Hedrich et al., 2010). As a result, these sites were not required to produce extensive evaluation evidence in order to operate like their Australian and Vancouver counterparts.

Despite clear findings from MSIC and Insite demonstrating the effectiveness of SIFs, both facilities operated for close to ten years without being granted any form of institutional legitimacy (Boyd, 2013). While each site was opposed by their respective governments, the

[1] An unsanctioned SCS has been operating in the Dr. Peter Centre in Vancouver's West End neighbourhood since 2002. The Dr. Peter Centre is a residential HIV/AIDs care facility that allows clients to access the supervised consumption services (McNeil, Dilley, Guirguis-Younger, Hwang, & Small, 2014). The site recently received approval from the Liberal government in January 2016 (Woo, 2016).

political battle surrounding Insite has largely shaped the history of SCS in Canada. In 2003, Health Canada granted Insite an exemption from the Controlled Drugs and Substances Act in an attempt to counter death and infection from the HIV epidemic in Vancouver's DTES. Insite continued operating under this exemption until the Conservative government was elected and refused to grant a continuing exemption (Cavalieri & Riley, 2012). With the Conservative government threatening to close Insite, site operators took the case to the Supreme Court of Canada in 2011. The court held that closing Insite would violate drug users' constitutional right to life and security of the person (Smith, 2015). The court stated that there was considerable evidence in favour of the SIF decreasing death and disease and little to no evidence that the site had a negative impact on public safety. Therefore, the Supreme Court concluded that under these circumstances, the Federal Health Minister should generally grant an exemption (Smith, 2015).

Although Insite was able to remain open, subsequent to the Supreme Court of Canada decision the Conservative Federal Government enacted Bill C-2, the Respect for Communities Act, that required new supervised injection sites to meet onerous criteria (Smith, 2015). Specifically, Bill C-2 undermined the Supreme Court decision by making it exceptionally difficult for SCS to be granted an exemption. Consequently, the restrictive regulatory framework governing SCS and these stringent criteria largely prevented the opening of additional sites throughout Canada (Boyd, 2013). Nevertheless, in 2015, Canada elected a new Liberal government which expressed greater support for harm reduction approaches than their predecessors. Once in office, the Liberals were slow to change existing legislation until the dramatic rise in overdose deaths over the course of 2016 forced them to take more immediate action (Kirkup, 2016). In December 2016, the Liberal government announced they were

reducing the criteria for opening SCS from twenty-six criteria to five (Zimonjic, 2017). As a result, in February 2017, three SCS in Montreal were approved by Health Canada. Several health authorities (including FH) have now submitted applications for their own sites and are awaiting approval from Health Canada.

2.3 Program Justification

2.3.1 Evidence of the effectiveness of supervised consumption sites

Abundant evidence supports the effectiveness of SCS from North America, Europe and Australia. Numerous studies have been conducted on facilities throughout Europe, at Insite in Vancouver, and at MSIC in Sydney.[1] A review of the literature on the effectiveness of SCS reveals that the introduction of SCS results in a reduction in overdose deaths, increased referrals and entry into detoxification and addiction treatment, reductions in HIV/HCV risk behaviour, improved access to medical treatment, health care, and other support services, safer injection education and practices, decreased drug-related disorder, and overall cost-savings. A summary of the literature related to each of these benefits is provided below:

1. **Reduction in overdose deaths:**

In 2011, a study by Marshall, Milloy, Wood, Montaner, & Kerr found a reduction in fatal overdose deaths in the vicinity of Insite after the site opened. During the period before Insite opened (Jan 1, 2001, to Sept 20, 2003), researchers examined population-based overdose mortality rates within a 500-metre radius of the SIF. Also, they looked at overdose mortality rates during those same periods for the rest of the city. The study found that the fatal overdose rates in the immediate vicinity of Insite decreased by 35% after the site opened. During the same

[1] It is important to note that here have been few thorough impact evaluation studies on European SCS, and the majority of the published research from Europe does not currently appear in English (Dolan et al., 2000). However, the available/accessible evidence from Europe is included in the summary of the literature that follows.

period, the fatal overdose rates in the rest of the city only decreased by 9.3%. These findings clearly demonstrate that a significant reduction in overdose deaths occurred due to the presence of Insite.

In addition, studies of Insite and MSIC found staff at both sites managed approximately 300 overdoses over an 18-month period (Kerr, Tyndall, Lai, Montaner, & Wood, 2006b; MSIC Evaluation Committee, 2003). Researchers estimated that a proportion of the overdoses occurring onsite may have been fatal had they occurred elsewhere (there has never been a fatal overdose death at Insite or MSIC). Insite estimated that between March 1, 2004 and July 1, 2008, eight to fifty-one overdose deaths might have been averted (Milloy, Kerr, Tyndall, Montaner & Wood, 2008a). Similarly, MSIC estimated that between four and nine deaths per year of operation may have been averted (MSIC Evaluation Committee, 2003). As well, one European study estimated that the likelihood of staying in the hospital for one night was ten times greater for someone who overdosed outside as opposed to someone who overdosed in a SCS (Jahresbericht 1996). Each of these estimates indicates that SCS has helped reduce the disability or death that may result from overdose events. By having trained medical professionals onsite to immediately manage overdose events, estimates indicate that several lives have been saved. By analyzing overdose risk behaviour and associated harms, Insite helped explain the mechanism through which SCS reduce overdose risk by addressing environmental forces (Kerr, Small, Moore, & Wood, 2007b). People who attended Insite believed they were at a reduced risk of fatal overdose because they were able to inject in the presence of medical professionals, had time to safely inject without feeling rushed, and were injecting in a safe environment without the risk of assault, robbery, or arrest.

2. Increased referrals and entry into detoxification and addiction treatment

Sites in Europe, Sydney, and Vancouver provided many referrals to their clients for detoxification and addiction treatment. Insite recorded 2,171 referrals to addiction treatment and other support services during a one-year period (Tyndall et al., 2006). In 2003, the MSIC Evaluation Committee found that frequent MSIC users were more likely to receive referrals than non-frequent MSIC users. Finally, in several European facilities, findings suggested that clients who received referrals at the centres and accessed these referral services experienced stabilization or improvement in social functioning and general health (Dolan et al., 2000). Therefore, the SCS is an important opportunity to provide referrals to the injection drug user population, and staff have been able to successfully connect drug users to meaningful resources in their community.

Understanding whether or not clients who were referred to treatment at the SCS actually entered treatment was another important indicator of the success of SCS facilities. In Sydney, MSIC users were significantly more likely to start treatment and therapy for drug use than non-MSIC users (MSIC Evaluation Committee, 2003). Similarly, Insite clients who used the facility at least weekly were 1.7 times more likely to enrol in a detoxification program than those clients who visited the facility less frequently. Among the Insite population, 18% began a detoxification program during the study period (Wood et al., 2006a). Researchers at Insite also examined detoxification service use after the introduction of the SCS and found a 33% increase in detoxification service use in the year after Insite opened compared to the year before implementation (Wood et al., 2007). Insite clients who entered detox were also 1.6 times more likely to enrol in methadone treatment and 3.7 times more likely to enrol in other forms of addiction treatment. Finally, individuals who entered detox began attending Insite less

frequently in the month after enrolling in detox compared to the month prior. These findings suggest that SCS users who attend the sites more often are not only entering detoxification treatment, but may also be successfully decreasing their drug use through these detoxification programs.

3. Reduction in HIV/HCV risk behaviour

While there are significant methodological challenges to attributing reductions in blood-borne viruses directly to SCS, considerable evidence suggests that SCS play a role in reducing HIV/HCV risk behaviour. Several European studies observed reductions in needle sharing and increased condom use among clients during the study period (Ronco, Spuhler, Coda, & Schopfer, 1996; Jacob et al., 1999). Insite researchers witnessed similar results with clients reducing their likelihood of sharing syringes by 69% during the study period and increasing their condom use by 30% (Marshall et al., 2009; Milloy & Wood, 2009). Also, evidence indicates that those clients who accessed medical care from nurses at Insite were more likely to use condoms than those who did not (Marshall et al., 2009). Another study at Insite found more consistent use of the SIF was associated with safer injecting practices including decreased reuse of syringes, increased use of sterile water, cleaning of injection sites and cooking/filtering of drugs (Stoltz et al., 2007). At the same time, more consistent Insite users were less likely to report rushed injections, a behaviour associated with non-sterile injection and increased risk of overdose. These findings highlight how education and supplies provided at the sites help promote safe sex and safer injection and ultimately reduce HIV/HCV risk behaviours among PWUD. Clearly, SCS policies prohibiting clients from engaging in risky injection behaviours when consuming drugs onsite may lead to further reductions in HIV/HCV risk behaviour and translate into behavioural changes offsite (Stoltz et al., 2007).

4. **Improved access to medical treatment and health care**

At MSIC and Insite, researchers found that nurses regularly provided care for injection related infections and provided referrals for off-site medical treatment (MSIC Evaluation Committee, 2003; Small, Wood, Lloyd-Smith, Tyndall, & Kerr, 2008). The MSIC evaluation also found that testing for blood-borne viruses was more common among clients than people who did not access MSIC. As well, one in every four MSIC visits involved the provision of health care services, and over 50% of the services provided by staff involved injecting and vein-care advice. Finally, interviews conducted with Insite clients revealed that Insite was often seen as a preferable venue for seeking medical treatment because the site has long operating hours and staff were more experienced caring for PWUD (Small et al., 2008). As injection related infections are one of the leading causes for ER visits and hospitalization among drug users, these findings demonstrate that medical treatment offered at the SCS likely reduces emergency room visits among PWUD (Kerr et al., 2005c).

5. **Safer consumption education and practices**

Results from MSIC and Insite evaluations indicate increased use of safer injection practices among clients who attend SIFs. The MSIC Evaluation (2003) found that nearly half of MSIC clients reported that their injection practices had become less risky than before they began attending the site. Similarly, 75% of Insite clients reported adopting safer injection practices after they began attending the site compared to their injecting practices before (Petrar et al., 2007). Interviews with Insite clients found that nurses were providing advice and education around safe injection practices in a safe and unhurried environment (Fast, Small, Wood, & Kerr, 2008), which likely increased knowledge and utilization of safer injection practices. At the same time clients reported that the environment at the facility encouraged them to adopt safer injection

practices both onsite and offsite. The Insite evaluation also compared injection behaviours between frequent and non-frequent Insite users as well as Insite clients and non-Insite clients. They found that frequent Insite users were 3 times more likely to use sterile water, 2.8 times more likely to swab injection sites, 2.8 times more likely to not rush during injections, 2 times more likely to dispose of syringes safely, and more than twice as likely not to share syringes than non-frequent Insite users (Stoltz et al., 2007). Finally, Insite clients were 70% less likely to inject drugs with a shared syringe than a non-Insite client; nevertheless, prior to Insite opening, these same clients were just as likely to use a shared syringe (Kerr, Tyndall, Li, Montaner, & Wood, 2005d). In other words, reduced syringe sharing could be directly attributable to Insite attendance and the interventions provided at the facility.

6. Decreased drug-related disorder

Common public concerns with introducing an SCS, such as increases in crime, public injection, and injection related litter, have been disproven by studies conducted in Sydney, Vancouver, Switzerland, and Germany. First, research from MSIC and Insite evaluating crime before and after site implementation revealed that no increases in crime within the vicinity of each SIF occurred (MSIC Evaluation Committee, 2003; Kerr, 2006a). Additionally, no significant changes in drug related activity and loitering in the vicinity of MSIC occurred, according to key-informants and police focus groups. MSIC and Insite counts of improperly disposed of syringes and injection related litter decreased after the introduction of each site (MSIC Evaluation Committee, 2003; Wood et al., 2004a). Moreover, testimonies from local residents and businesses in Sydney further supported this reduction in injection related litter as these groups reported seeing fewer incidents after the site opened. Finally, reports and counts of public injection in Sydney, Vancouver, and across Europe decreased after sites were

implemented (MSIC Evaluation Committee, 2003; Wood et al., 2004a; Ronco et al., 1996; Kemmesies, 1995). Also, research from Switzerland and Germany highlighted overall reductions in the visibility and public nuisance of the drug scene after sites opened (Ronco et al., 1996; Kemmesies, 1995).

7. **Estimated cost savings:**

Reports from MSIC and Insite indicate that significant cost-savings can occur by introducing a SCS. By estimating the associated costs of deaths and disease that are potentially averted by the site and accounting for the operational costs of the site, MSIC research suggests that the benefits cost-ratio ranges from 1.20 (low estimate) to 1.97 (high estimate) (MSIC Evaluation Committee, 2003). Similarly, researchers from Insite have estimated that the program saves $6 million per year of operation (Andresen & Boyd, 2010). Insite researchers conservatively estimated that, on average, Insite prevents 35 new cases of HIV and about 3 deaths per year (Andresen & Boyd, 2010). The Insite evaluation estimated that over $18 million and 1175 life years are saved by the SIF, reducing the prevalence of HIV and HCV over a ten-year period (Bayoumi & Zaric, 2008). Therefore, evidence indicates that SCS are an effective use of public health spending as they lessen the burden of death and disease related to injection drug use thereby reducing costs.

2.3.2 Epidemiological evidence demonstrating the need for SCS in Surrey

The number of illicit opioid overdose deaths in BC has dramatically increased over the past several years. According to the Coroner's Service Report (2017), the average number of overdose deaths in BC from 1990-2014 was approximately 250 deaths per year. Nevertheless, as indicated in **Figure 2.1**, the number of illicit overdose deaths rose to 510 deaths in 2015 and that

number climbed even more drastically to 922 deaths in 2016 (Coroner's Service Report, 2017). Findings suggest that illicit fentanyl, a potent opioid 100 times more toxic than morphine, is responsible for the large increase in illicit drug overdose deaths (**see Figure 2.2)**. From January to November 2016, illicit fentanyl was detected in 60% of drug overdose deaths in BC (BC Coroner Service, 2016). This alarming increase in overdose deaths resulted in provincial health officer, Dr. Perry Kendall, declaring a public health emergency in BC on July 27, 2016 (Government of B.C., 2016).

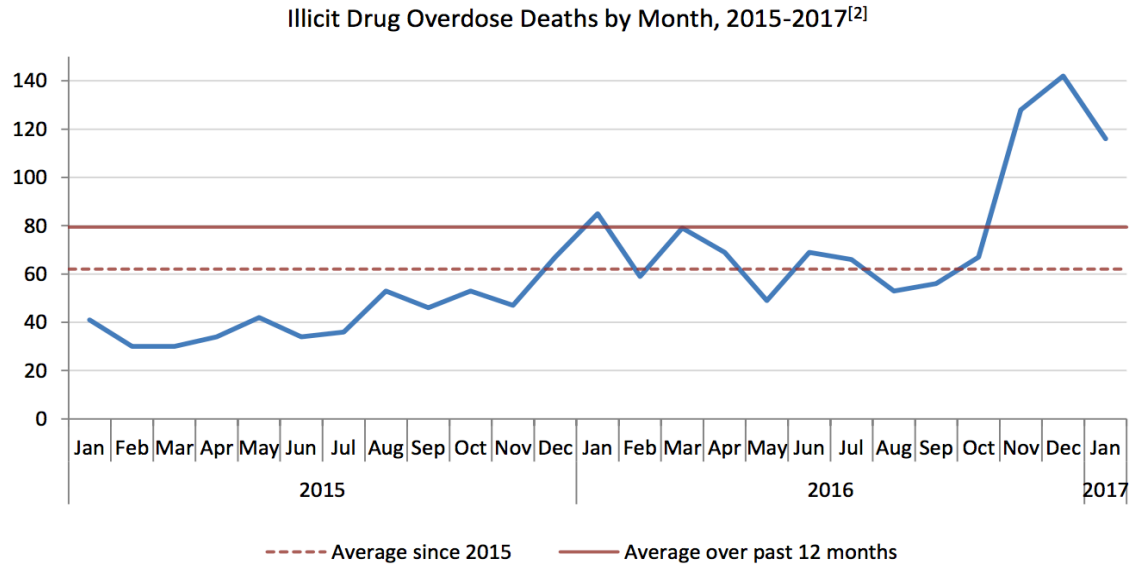

Figure 2.1: Illicit drug overdose deaths by month in BC, 2015-2017 (Coroner's Service Report, 2017)

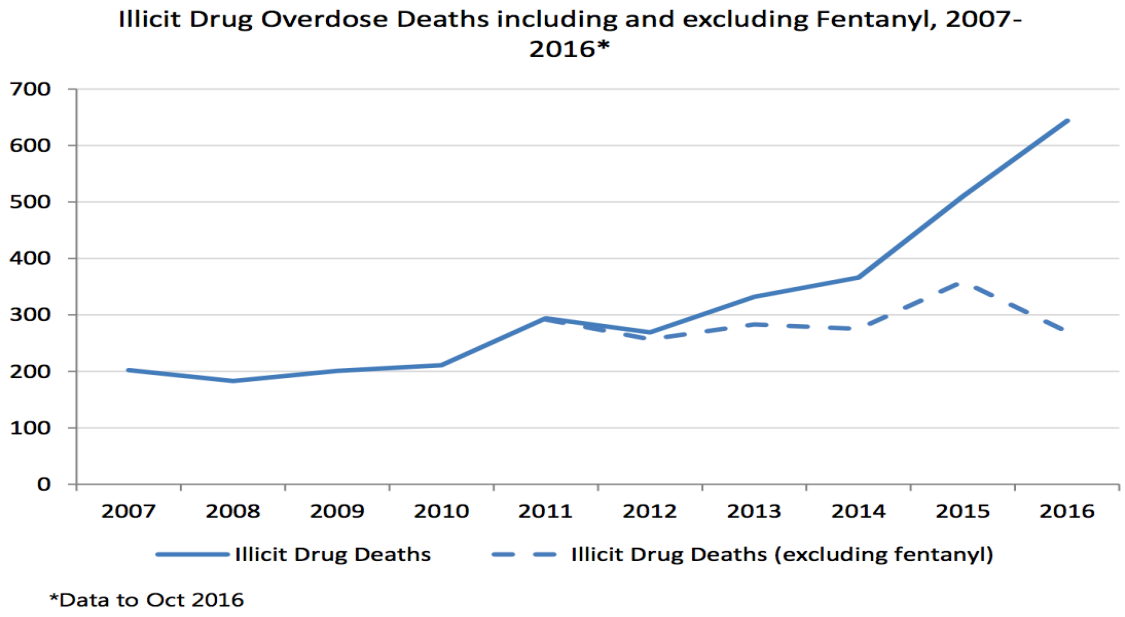

Figure 2.2: Illicit drug overdose deaths including/excluding fentanyl, 2007-2016 (Coroner's Service Report, 2017)

In 2016, the FH Region had the second highest number of illicit drug overdose deaths in the province with 310 overdose deaths occurring (approximately 33% of all overdose deaths in the province) (Coroner's Service Report, 2017). Among the FH municipalities, Surrey had the highest number of overdose deaths, BC Ambulance Service attendances, and emergency department (ED) visits (Coroner's Service Report, 2017; Patient Care Records data from BC Emergency Health Services, 2017; Fraser Health Emergency Department, 2017). FH epidemiological data and data from BC ambulance services show that the problem is most acute on 135a Street between 106 and 108 avenues in the area known by locals as "the strip" in the Whalley neighbourhood of Surrey. Similar to Vancouver's DTES area, the 135a Street area is home to a street entrenched population where homelessness, poverty, crime, unemployment, mental health issues, and drug use are common challenges. The nearest hospital to the 135a area, Surrey Memorial Hospital (SMH), had 1643 overdose visits in 2016 compared to 170 visits

in 2015. Because many active drug users are admitted to SMH, and are without a safe space to use drugs, injection related litter and public injection are regularly reported in and around the hospital.

2.4 Program Context

2.4.1 FH Enhanced Overdose Prevention and Response Strategy

In response to the opioid overdose crisis, FH launched an Enhanced Overdose Prevention and Response Strategy in July 2016. The strategy includes a variety of actions along the prevention to recovery continuum that target different population groups depending on their relationship with substance use. **Figure 2.3** summarizes these interventions and the range of populations targeted by each service. From left to right across the figure, service level intensity increases while the number of people targeted by each intervention decreases. On the left, interventions such as community response, education and training target all Fraser Region residents and have the largest population health impact. Such preventative actions can help mitigate the impacts of drug use as well as socioeconomic factors contributing to morbidity, mortality, and street entrenchment among PWUD (Fischer et al., 2004). Moving right across the figure, interventions specific to substance users such as naloxone distribution, naloxone training and detox/daytox with OAT target more mild to moderate substance users. Finally, treatment and recovery services such as residential treatment facilities, supervised consumption services, and tertiary treatment target people with severe substance use disorders. Therefore, the two SCS sites are just one of many services being offered by FH to help address the overdose crisis.

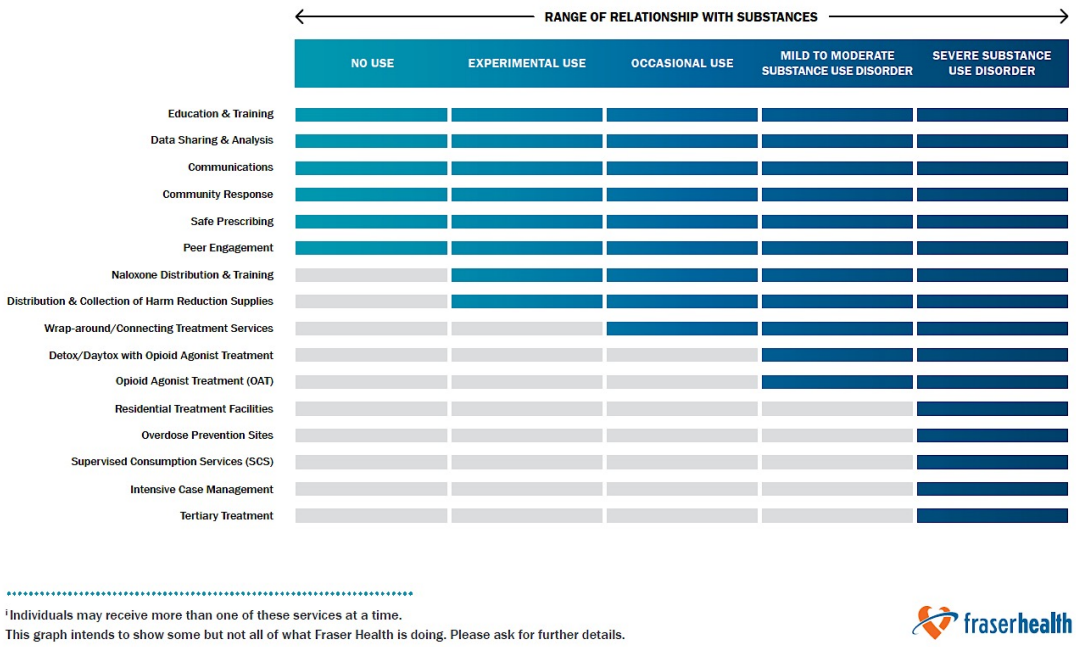

Figure 2.3: Prevention to recovery continuum (FHA, 2017)

A description of the specific services in the Enhanced Overdose Prevention and Response Strategy are detailed below:

1. **Prevention of drug use and habituation:**

- Creation of intersectoral working group to promote prevention and inform local context
- Establishment of provincial partnerships to promote opioid safe prescribing guidelines
- Establishment of communication and outreach efforts with community partners
- Provision of substance use education at FH facilities and throughout the region

2. **Harm Reduction:**

- Distribution of harm reduction supplies and increased safe needle disposal/collection

- Implementation of Supervised Consumption Service(s)

3. **Treatment for Substance Use:**

- Continued operation of the Quibble Creek Sobering & Assessment Centre and Creekside Withdrawal Management Centre
- Expansion of Opioid Agonist Treatment (OAT) across FH facilities and among community partners
- Establishment of residential treatment facilities

4. **Response to overdose events:**

- Training in overdose prevention, recognition, and response education
- Dispensing Take Home Naloxone (THN)
- Training on Naloxone Administration for community partners (RCMP, Surrey Fire, etc.), PWID, and the general public.

2.4.2 Community Response to Overdose-Crisis

Within the FH context, the City of Surrey and local RCMP have launched a "City Response Plan" to address the overdose crisis and the complex social issues in the 135a neighbourhood. The City of Surrey created the plan to address increased challenges as a result of homelessness, mental health issues, and fentanyl use in the 135a area (City of Surrey, n.d.). As part of the response plan, the City of Surrey created the Surrey Outreach Team, a group focused on enhancing outreach and presence in the 135a street area to increase protections for vulnerable populations. The team includes 12 RCMP officers and 4 by-law officers in the area 24 hours a day, 7 days a week. Their goals include targeting those who are preying on

vulnerable populations, increasing public safety and security, and connecting those in need with addiction and social services.

In addition, existing community agencies and programs in Surrey continue to provide support to the drug using population during this public health crisis. Lookout Emergency Aid Society, a non-profit charity organization, delivers nineteen programs relating to health and homelessness in the area. They operate the Gateway Shelter on 135a Street –a facility offering low-barrier services including a free medical clinic, a non-profit dental clinic, mobile harm reduction education, harm reduction supplies, outreach activities, a low-cost housing facility, peer-distribution of injecting equipment, women specific programming, a high-protein supplemental food bank, a community garden and support lounge for individuals affected with HIV/AIDS and hepatitis C. Referrals are also made to various services including primary care, mental health, and substance use services and supports.

Several kilometres from 135a Street and the Gateway Shelter is the Quibble Creek Sobering and Assessment Centre (SAC) located on 94a Avenue directly across from SMH. While the number of overdose events around Quibble Creek SAC is not as high as 135a Street, the site currently provides services to active and recovering users who are able to temporarily access the site to safely sober up (maximum stay of 23 hours). Quibble Creek SAC serves individuals who are age 16 and over who are under the influence of alcohol and/or drugs. Several other FH services operate within the same building as the Quibble Creek SAC including Surrey Substance Use Services, Primary Care Services, and Opiate substitution services (OAT). In close proximity to Quibble Creek SAC, the Creekside Withdrawal Management Centre provides detox and withdrawal management services, including long-term supervised withdrawal from alcohol and other chemical dependencies, supportive counselling, assessment and referral.

2.5 Program Description

As of December 2016, FH submitted applications to Health Canada for two supervised consumption service sites in Surrey. Pending approval, these sites have a targeted opening date of Spring/Summer 2017. At both sites, supervised consumption services will be integrated with existing health services in the community with the first proposed site being located on 135a Street adjacent to the Gateway Shelter and the SHOP Clinic and the second being located in the Quibble Creek SAC on 94a Avenue and adjacent to SMH. A key feature of both proposed sites is their integration with existing health services and their provision of OAT.

Each site will offer supervised consumptions services –a key component of the provincial and regional response to BC's public health emergency declared last April. According to the FH website, supervised consumption services are "health services where individuals can inject or consume [pre-obtained illicit] substances in a hygienic environment under the supervision of trained staff, and have opportunities to engage in other health and social services." SCS allow clients to administer their drugs not only through injection, but orally or intranasally as well. The SCS will also offer safer consumption supplies, education on safe injection techniques and infection prevention, overdose prevention and intervention, medical and counselling referrals, referrals to substance use treatment, housing and other support services. Naloxone and oxygen will be present at both sites for staff to reverse overdoses.

The 135a SCS will offer services from a temporary portable adjacent to the Gateway Shelter to people consuming injection, oral, or intranasal drugs. The proximity of the SCS to the Gateway Shelter allows for interface between staff at the SCS and shelter, opportunities for clients to access nearby (essentially on-site) services, and extra staff support in the case of emergency. The SCS will be open 18 hours a day, 7 days a week. The site will be staffed with

registered nurses and harm reduction workers and operated jointly by both FH and Lookout Emergency Aid Society. When clients first enter the site, they will sign in at the reception desk and wait in the waiting area before accessing the consumption area. The consumption area will include seven consumption booths as well as a space for staff and staff washroom. After clients are finished consuming their substances, they will exit the building through a door in the consumption area. However, if clients need to be monitored further, they will remain in the temporary portable or will be escorted to the Gateway Shelter. A detailed floor plan of the 135a SCS portable can be found in **Appendix A**.

The Quibble Creek SAC SCS will be accessible to Quibble Creek SAC clients only. Once again, FH anticipates the proximity of the SCS to primary care, addiction treatment, and mental health services will be beneficial for both clients and staff at the SCS. The site will be open 8 hours a day, 7 days a week with buzz in/ buzz out access to the secured building. The site will be operated by FH and staffed with registered nurses and health care workers with a substance use specialization. The site will be smaller than the 135a SCS with only two consumption booths and room for staff supervising the area. As mentioned previously, this site will be located within the Quibble Creek SAC facility and will be restricted to clients who have been admitted to the facility. A detailed floor plan of the Quibble Creek SCS can be found in **Appendix B**.

2.6 Program Objectives

The short-term objectives for this program include:

- Increase the knowledge of safe injection among at least 25% of clients by 2018.

- Provide a low-barrier, hygienic, safe and supervised injection environment to PWUD in the community surrounding each site.
- Reduce the amount of injection related litter and public injection in the vicinity of each SCS by 2018.
- Ensure all clients have access to safer injection supplies by 2018.
- Provide referrals to detox or other social services for at least 25% of clients by 2018.
- Improve stakeholder engagement and buy-in for the program by 10% from baseline by 2018.

The medium-term objectives for this program include:

- Improve the utilization of safer injection practices among 25% of clients who attend the site by 2019.
- Increase the number of referred clients accessing detoxification services or addiction treatment (including OAT) to 15% by 2019.
- Ensure at least 50% of clients are satisfied with SCS services by 2019.
- Increase stakeholder engagement and buy-in for the program by 25% from baseline by 2019.

The long-term objectives for this program include:

- Reduce the number of overdose deaths among PWUD in the Fraser Region by 2020.
- Reduce the incidence of infectious diseases among PWUD in the Fraser Region by 2020.
- Address social issues/determinants (housing, poverty, etc.) through referrals and supports among 5% of clients by 2020.

2.7 Program Activities

The activities for this program include:

- Provide two safe and accepting supervised consumption spaces that offer consumption instruction, overdose intervention, and some primary care services
- Provide safer injection and sex education to clients
- Provide safe syringe and injection paraphernalia disposal education to clients
- Provide safer consumption supplies to clients
- Provide referrals to detox, addiction treatment and other social services
- Share the evaluation results with stakeholders on an ongoing basis
- Adapt the program to meet the needs and improve satisfaction of SCS clients
- Address concerns regarding the site from community residents, businesses, and other stakeholders

2.8 Program Stakeholders

The stakeholders for this program include:

1. The population who will be accessing the SCS (SCS clients)
2. PWUD in the vicinity of each site
3. FH Employees/Organizations
    - FH Senior Executive Committee
    - PPH and MHSU SCS implementation team
    - SCS staff
4. Community members, partners, or organizations
    - Surrey BIA

- Surrey School District
- RCMP
- City of Surrey
- Lookout Emergency Aid Society

5. Provincial stakeholders:
    - BCCDC
    - Ministry of Health
    - Health Canada

2.9 Program Logic Model

Appendix C shows the program logic model for the FH SCS. The program logic model is a simplified schematic which demonstrates the underlying logic for a program. The logic model illustrates the expected pathway or links between inputs, activities, outputs and outcomes. This program logic model also shows the target groups that will be the focus of the program activities and outcomes as well as the strategies employed to achieve these outcomes. There are specific activities and outcomes for two different target groups in the SCS program. The first target group is the population accessing the SCS (SCS clients). The second target group includes consultation stakeholders (community members, partners, or organizations), FHA Senior Executive Committee, and provincial stakeholders. For the purpose of this logic model, the "program" consists of the two SCS that will be implemented (with Health Canada approval).

3. Evaluation Methodology

3.1 Evaluation Type

This evaluation will be both a process and outcome evaluation. A process evaluation focuses on how a program is implemented/operates and examines whether the program is being delivered as intended. An outcome evaluation determines the extent to which anticipated and unanticipated outcomes were achieved and assesses the effectiveness of the program (Patton, 2010).

3.2 Evaluation Questions

Three main evaluation questions, two process and one outcome, are included in this evaluation plan. Each evaluation question has several sub-questions with respective indicators, data collection strategies, responsibilities, and timelines. The evaluation questions, indicators, and data collection strategies have been developed in consultations with the FH Senior Executive Committee, the SCS implementation team, the Surrey RCMP, the City of Surrey, and the Surrey BIA. Each evaluation question and related sub-question are listed below:

1. **Are the services being provided as intended at the two SCS? (Process)**
    i. What is the pattern of client attendance at each SCS?
    ii. Is each SCS providing wound care, vaccinations, and other health services onsite?
2. **Are SCS services adapting to client and community needs? (Process)**
    i. Have there been any changes to the way SCS services are offered at each site?
    ii. Are clients satisfied with the services offered at each SCS?
    iii. Are community members and key stakeholders supportive of each SCS?

3. **Are the intended benefits of each SCS being recognized? (Outcome)**
    i. Has there been a decrease in OD deaths among PWUD in the vicinity of the site?
    ii. Has there been decreased emergency health care utilization among PWUD in the vicinity?
    iii. Has there been a reduction in HIV/HCV risk behaviour among clients?
    iv. Has there been increased interest/initiation of accessing detoxification services or addiction treatment (including OAT) as a result of referrals from SCS sites?
    v. Has the amount of injection related litter in the area immediately surrounding the SCS sites decreased?
    vi. Has the amount of public injection in the area immediately surrounding the SCS sites decreased?
    vii. Has the amount of related crime remained the same in the vicinity of each SCS?

3.3 Evaluation Approach

The evaluation of the FH SCS will use a utilization-focused approach. A utilization-focused approach is based on the principle that an evaluation's main purpose is to be useful to its intended users, and it has two main elements (Patton, 2011): First, the primary users of the evaluation must be identified at the beginning of the evaluation process to ensure that their needs for the evaluation are defined and clarified. Second, the evaluators must ensure that these intended uses will guide every decision made throughout the evaluation process (Patton, 2011).

A utilization-focused approach is appropriate for this evaluation, as one of the main goals is for stakeholders to have pragmatic results that will allow them to recognize, assess, and

respond to site outcomes as the program evolves. By working closely with stakeholders to develop the evaluation plan, the maximum utility and value for FH will hopefully be achieved. As SCS are highly controversial, the evaluation must provide evidence that will demonstrate whether or not the program is achieving its objectives. If the program is not meeting its objectives, FH will need to be able to use the results to inform decisions and improve the performance of the program. Therefore, the primary intended users of the evaluation will continue to be engaged in planning and revising the evaluation as the program evolves. One potential drawback to the utilization-focused approach may be the perceived lack of objective or independent findings that will result from the evaluation. However, this limitation will hopefully be mitigated through triangulation of the findings using secondary data sources.

3.4 Evaluation Design

The proposed evaluation will use a mixed methods approach combining qualitative and quantitative data. The evaluation will also rely on mixed methods to improve validity of the findings drawing from the concept of triangulation.

3.5 Methodology from previous evaluations of supervised consumptions sites

For the purposes of this evaluation, it is important to replicate the methodology used in previous evaluations wherever possible to ensure that comparability is feasible and data collection strategies are scientifically based. Therefore, an extensive review of the literature was conducted to examine the indicators measured and data collection strategies used in the evaluations of SCS in Vancouver, Sydney, and across Europe. The literature review was refined to examine only those indicators and data collection strategies most relevant to the evaluation

questions in the current evaluation. Due to resource limitations in the current evaluation, an analysis of the feasibility of previous evaluation methodology and indicators was also conducted. A summary of the methodology used in previous evaluations and the feasibility of these strategies for the current evaluation is available in **Appendix D**.

4. Data Collection and Analysis

4.1 Evaluation Matrix

The evaluation matrix is a key piece of the evaluation, identifying exactly how the evaluation questions will be answered in a concise format. The evaluation matrix is included in **Appendix E**, and is an easily adaptable document that can be modified as the program progresses to meet the needs of FH and other key stakeholders of the SCS. Each evaluation question and sub-question is described in the matrix along with the respective indicator(s) for each question. The indicators chosen to answer each question also have unique data sources, collection methods, timeframes, and associated responsibilities.

4.2 Data Collection Strategies

The data collection strategies that will be used to examine the evaluation plan indicators are discussed below. Specifically, a description of each data collection strategy, the deadline for data collection activities, and the indicators measured by each data collection tool are outlined in detail. The data collected will be a mix of both quantitative and qualitative data including data collected from an access database, clinical notes, surveys, informal interviews, surveillance tools, comment cards, and secondary data from the BCCDC, BC Coroner's Service, RCMP, emergency services, and the City of Surrey. These data collection tools are also described in

Appendix F at the end of this report. As mentioned previously, many of these data collection strategies and tools are adapted from methodology used in previous evaluations.

1. **Access Database**

Description: An access database will be used at each site to collect intake data and site operational data. Client intake data will be minimal to ensure the service is low barrier. Instead of requiring clients to provide their legal name, staff will ask clients to provide a unique "handle" or codename upon entry to the site. This handle will act as an identifier and allow staff to track the number of unique clients in the database. Clients will not be asked for their PHN; however, demographic information such as age, gender, and ethnicity will be tracked. The access database will also include space for clinical notes. This database will be adapted from the database used by Insite.

Deadline: Baseline

Indicators tracked in access database:

- demographic information (including age, gender, and ethnicity)
- # of client visits
- # of unique clients
- # of services used by clients
- # of OD events
- # of OD events successfully managed onsite
- # of emergency service calls and attendances to each site
- # of harm reduction supplies provided
- # of clients receiving safe injection education
- # of clients referred to OAT, MHSU and withdrawal management services

2. Client Satisfaction Survey

Description: In-person, interviewer administered, client satisfaction surveys will be administered to all SCS clients who agree to participate. Clients of the 135a SCS will be encouraged to participate in the survey which will be administered by Lookout staff at the adjacent Gateway Shelter. The survey will be administered at the Gateway Shelter because survey administration at the SCS would be limited by time, space, and resource constraints. Clients of the Quibble Creek SAC will be administered the survey by staff at Quibble Creek SAC.

Clients who complete the survey will receive a small cash incentive ($2 CDN) to compensate them for their time. Participants will also be asked to provide their unique handle on the survey and staff should note in the database if clients have completed the survey. Many of the questions from the survey have been adapted from the Insite client satisfaction questionnaire. The survey will ask for early feedback from clients at 1 month to facilitate rapid course correction if required. The survey will then be administered again at 6 months once services are expected to have stabilized. The survey administered at 1-month post-implementation is attached to this report in **Appendix F (7.6.1)** and the survey administered at 6-months post-implementation is attached to this report in **Appendix F (7.6.2).**

Deadline: 1 month, 6 months

Indicators evaluated by client satisfaction survey:

- # of clients attending the site (frequency)
- # of referrals from stakeholders to SCS
- # of clients reporting needle sharing
- % of clients that report being satisfied with services offered at SCS
- # of clients receiving safe consumption education from the SCS

- # of clients receiving referrals to medical or social services from the SCS

3. Persons Who Use Drugs in the Community Survey

Description: A survey will be administered to persons who use drugs (PWUD) in the surrounding community of 135a to understand if they are satisfied or dissatisfied with the services at the SCS and why. The PWUD in the community survey will not be administered in the vicinity of Quibble Creek SAC as the site will only be accessible to clients. This survey will target PWUD who have stopped attending SCS sites (or never attended a SCS) and will be administered by Lookout Shelter staff at the Gateway Shelter. The Gateway Shelter is a desirable setting for survey administration because PWUD in the 135a vicinity who do not attend the SCS may still visit the shelter. Also, Lookout staff are more familiar with the population and will be able to help recruit PWUD in the community who have stopped or do not attend the site. Participants will receive a small cash incentive ($2 CDN) for completing the survey. There is space for participants to provide their unique handle; however, those participants who have not attended the site will not have a handle. Therefore, Lookout staff administering the survey will need to be more cautious of tracking who has completed the survey to avoid duplication. Like the client satisfaction survey, many of the questions from the survey have been adapted from the Insite client satisfaction questionnaire. The survey will ask for early feedback from PWUD in the community at 1 month post SCS implementation to facilitate rapid course correction if required. The survey will then be administered again at 6 months once services are expected to have stabilized. The survey that will be administered at 1-month post-implementation is attached to this report in **Appendix F (7.6.3)** and the survey to be administered at 6-months post-implementation is attached to this report in **Appendix F (7.6.4)**.

Deadline: 1 month, 6 months

Indicators evaluated by PWUD satisfaction survey:

- # of PWUD in community who have attended or are attending a site (frequency)
- # of PWUD in community who have stopped attending a site and the reasons why they have stopped
- # of referrals from stakeholders to SCS
- # of PWUD in the community reporting needle sharing
- % of PWUD who report being satisfied with services offered at SCS (if they have attended a site)
- # of PWUD in the who community have received safe consumption education from the SCS (if they have attended a site)
- # of PWUD in the community who have received referrals to medical or social services from the SCS (if they have attended a site).

4. **Community and Business Persons Survey**

Description: A survey will be administered to community members and business-owners in the surrounding community of 135a and Quibble Creek SAC. The survey will examine community attitudes and impact of the SCS on businesses and residents as well as perceived changes in the neighbourhood as a result of the SCS. The survey will be available online through SurveyMonkey and a link to the survey will be mailed to residents and business persons within a 500 m radius of each site. The survey administered 1-month pre site implementation is attached to this report in **Appendix F (7.6.5)** and the survey administered at 6 months post site implementation is attached to this report in **Appendix F (7.6.6)**.

Deadline: 1 month (Pre), 6 months (Post)

Indicators evaluated by Community and business persons survey:

- # of community members/business persons who believe the SCS will have a positive/negative impact
- # of community members/business persons reporting public injection
- # of community member/business persons reporting injection related litter
- # of community members/business persons who believe various advantages will occur as a result of the SCS
- # of community members/business persons who believe various concerns will occur as a result of the SCS
- % of community members/business persons who are supportive of SCS within vicinity of their residence/business

5. Key Informant Interviews

Description: Key informant (qualitative) interviews will be conducted with site managers from each SCS and may also be conducted with the SCS implementation and monitoring team. The goal of the key informant interviews is to understand if there have been any changes or should be any changes to the way SCS services are offered at each site. Researchers will use a recording device to record the interview, and FH staff will transcribe responses verbatim. The interviews will be conducted with key informants at one-month post site implementation to allow for rapid course correction. The interview will be administered again at 6 months once site operations and procedures are expected to have stabilized. The interview guide is attached to this report in **Appendix F (7.6.7).**

Deadline: 1 month, 6 months

Indicators evaluated by key informant interviews with FH staff:

- # of key informants who believe the sites are operating as intended

- # of key informants who believe the sites are achieving their intended outcomes
- strengths and challenges of each site
- changes to the way SCS services are offered
- # of services offered (have services been added/removed?) Why?
- # of similarities and differences between sites? Why?

6. Public Injection/Injection Related Litter Tracking Tool

Description: Standardized measures of public injection and injection related litter will be conducted to examine the impact of the SCS sites on these indicators. For the purposes of the evaluation, public injecting will include any person(s) seen injecting illicit drugs and injection related litter will include publicly (improperly) discarded syringes, syringe wrappers, syringe caps, sterile water containers, and "cookers". The person(s) recording counts will walk through the study zone in a similar pattern on each outing and data collection will be structured evenly throughout the week. Tracking will occur at each SCS within an a priori defined geographical area in the neighbourhood at a priori-defined times of the week. The a priori defined geographical area for the 135a SCS is defined by the map in **Appendix F (7.6.8).** The map defining the geographical area for the Quibble Creek SAC is currently being created by an FH Epidemiologist. However, the area that will be included in the study zone will resemble the area described by the map in **Appendix F (7.6.9)**. Each map covers at least a 500-metre radius area around each SCS and is divided into zones based on geographical boundaries that confine the area. The zones are also characterized by the frequency of public injection and injection related litter that occur within the zone boundaries (see map legend for details). The 135a zone was adapted from the area used in the Lookout Emergency Aid Society's daily syringe/injection litter

collection program called 'Rig Dig'. Because Lookout has tracked injection related litter over the past year, FH can use their data to triangulate results from the current evaluation.

FH has also partnered with Lookout to track injection related litter in the 135a area as well as the Quibble Creek SAC area. The Lookout Rig Dig team will track injection related litter by walking through the 135a study zone Mondays, Wednesdays, and Fridays from 9-11 am (during Rig Dig). They will also track injection related litter in the Quibble Creek SAC study zone Mondays, Wednesdays, and Fridays from 1-3pm. Public injection will be tracked separately from injection related litter with Mental Health Workers conducting the tracking. Mental Health Workers will walk through the Quibble Creek study zone Mondays, Wednesdays, and Fridays from 9-11 am to ensure individuals publically injecting are recorded. Mental Health Workers will also track public injection in the 135a study zone on Mondays from 1-3 pm; Wednesdays from 3-5 pm; and Fridays from 5-7 pm. The 135a times for tracking public injection are similar to the methodology used in the Insite evaluation. Public injection is also most frequently reported in the afternoons in the 135a vicinity. Based on the Insite evaluation, the largest changes in patterns of public injection and injection related litter will occur within the first six weeks of SCS implementation (Wood et al., 2004a). Therefore, tracking will occur six weeks pre SCS implementation and six weeks post. The tracking tools for recording public injection and injection related litter are attached to this report in **Appendix F (7.6.10).**

Deadline: 6 weeks pre site opening, 6 weeks post site opening

Indicators evaluated by public injection/injection related litter tracking:

- # of people injecting in public before and after site opening
- # of improperly discarded syringes (or injection related litter) in the vicinity of each SCS before and after opening

7. **Comment Cards**

Description: Comment cards will also be used to supplement the Client Satisfaction Survey. Comment cards will be available at the front desk of each SCS. Clients will be able to anonymously and quickly provide feedback about their satisfaction with the SCS as well as their experiences at the SCS. The comment card format is attached to this report in **Appendix F (7.6.11).**

Deadline: Ongoing

Indicators evaluated by comment cards:

- % of clients that report being satisfied with services offered at SCS (surveyed onsite)
- # of clients attending the site (frequency)
- # of referrals from stakeholders to SCS

8. **Secondary Data Collection**

Description: For several indicators in the evaluation plan, secondary data will be collected from different sources. FH has requested or obtained access to secondary data from the Coroner's Records, Emergency Services, RCMP, SMH, BCCDC, OAT facilities, MHSU, & Creekside, the City of Surrey, and Lookout Emergency Aid Society. Plans for retrieving this data or partnering with sources to collect data have been established. **Table 4.1** provides an overview of the secondary data sources, indicators, and deadlines for data collection.

Secondary Data Source	Indicators	Deadline
Coroner's Records OR Emergency Services (Ambulance, Fire, RCMP)	# of OD deaths in vicinity before and after site opening (500m)	Baseline, monthly
Emergency services (Ambulance, Fire, RCMP)	# of emergency service calls and attendances	Baseline, weekly
Emergency services (Ambulance, Fire, RCMP) records of transport OR SMH records of OD patients	# of related ED presentations from vicinity of SCS (500m)	Baseline, weekly
BCCDC Take Home Naloxone (THN) Kit reporting	# of THN kits provided onsite	6 months; will be retrospective and include all distribution since opening
OAT facilities intake questionnaire	# of clients accessing OAT	Baseline, 6 months
OAT facilities database(s)	# of clients who are accessing OAT actually starting OAT	Baseline, 6 months
MHSU & Creekside databases	# of clients requesting/accessing withdrawal management services, mental health services, and MHSU services	Baseline, 6 months
City of Surrey Works Yard	# of complaint calls related to injection litter	6 weeks pre/6 weeks post for triangulation with injection related litter tracking
City of Surrey	# of complaint calls related to public injection	6 weeks pre/6 weeks post for triangulation with public injection tracking
Lookout Emergency Aid Society 'Rig Dig' tracking	# of improperly discarded syringes and injection related litter	1 year pre/1 year post for triangulation with injection related litter tracking
RCMP (RMS data)	# of crimes committed in the vicinity (crimes include drug trafficking, assaults and robberies, and vehicle break-ins and vehicle theft in the 500-metre radius of the site)	12 months pre, 12 months post

Table 4.1: Secondary data sources, indicators, and deadlines overview

4.3 Data Analysis Methods

The evaluation will use a combination of quantitative and qualitative data analysis methods to analyze findings. The goal of the analysis is to answer each evaluation question in order to understand if each SCS is meeting targeted program objectives. A detailed overview of the data analysis plan for each data collection strategy is outlined below:

1. **Access Database:**

Data from the access database (with the exception of clinical notes) will be analyzed using quantitative data analysis methods. The number of client visits, frequency of client visits, services used by clients, client demographic information, as well as the number of OD events, emergency service calls, emergency service attendances to each site, injection education, referrals and harm reduction supplies provided will be counted using data analysis software such as Excel or Statistical Analysis Software (SAS). A frequency distribution for each indicator will be created as well as measures of central tendency and dispersion (descriptive statistics). Monthly frequency distributions will be helpful in exploring each of the indicators tracked in the access database. The data will also be disaggregated across different variables and subcategories of variables to explore patterns. For example, client demographic characteristics may be disaggregated to examine various indicators for specific population groups. Access database findings will be important for understanding a range of evaluation questions (client attendance, OD deaths, emergency health care utilization, HIV/HCV risk behaviour, and referrals); therefore, analysis will be ongoing to produce findings for stakeholders on a regular basis.

2. **Client Satisfaction and PWUD in the Community Surveys**

Survey data from the closed-ended questions in the Client Satisfaction Survey and the PWUD in the Community Survey will be inputted into Excel or SAS and analyzed using the

quantitative methods described above. Closed ended survey questions among clients/PWUD in the community will help identify how participants are being referred to the sites, how many are sharing injection equipment, how many are receiving safe consumption education, how many are receiving referrals to medical or social services from the SCS, and how many are satisfied with the SCS. Results from both surveys will be compared using significance testing to analyze any differences between client and non-client responses. Results from surveys administered at 1 month and 6 months post site implementation as well as surveys from different SCS facilities will also be compared.

Depending on the number of open-ended survey question responses, data will be inputted into Microsoft Word or qualitative analysis software such as NVivo11. Because qualitative data from the surveys will likely be limited, Microsoft Word may be sufficient. According to LaPelle (2004), Microsoft Word is a suitable and efficient alternative to qualitative data analysis software when working with basic qualitative data. Once data is inputted into Microsoft Word or NVivo11, survey questions will undergo thematic content analysis to help identify salient issues and typical responses among the participants. Green and Thorogood (2014) cite thematic content analysis as the most common approach used in qualitative data analysis and characterize it as an effective stand-alone method for presenting the key elements of participant responses. Using an inductive coding approach, key themes will be identified as the data is analyzed. Emerging themes could provide useful findings on the impact and effectiveness of the SCS as well as SCS satisfaction among clients/PWUD in the community.

3. The Community & Business Persons Survey

The results from the Community & Business Persons Survey will be stored in SurveyMonkey. Therefore, these results will either be analyzed directly in SurveyMonkey using

features within the online survey provider, or the data may be exported and analyzed in Excel. Survey responses will be analyzed using both quantitative and qualitative data analysis methods similar to the client/PWUD surveys. Significance testing between the pre and post surveys as well as 135a versus Quibble Creek vicinity respondents will be important for answering several evaluation questions. Significant differences in perceived impact of SCS, support for SCS, advantages or concerns around SCS, and public injection and injection related litter reporting pre and post site implementation could indicate that the SCS is influencing community and business persons' support towards the SCS and impacting public order. Finally, differences between 135a versus Quibble Creek vicinity respondents could provide opportunities for program adaptations or interventions specific to each SCS site.

4. Key Informant Interviews

Transcripts from key informant interviews will be imported into NVivo11 for thematic content analysis. The interview data will also be coded using an inductive coding approach to allow for new themes to emerge. Key themes that emerge from the qualitative interviews will be extremely useful for assessing several process evaluation question indicators such as changes to the way SCS services are offered, differences between services at each SCS site, and strengths and weaknesses of each SCS site. By conducting key informant interviews as early as 1 month post site implementation, findings from the analysis will allow FH to change program activities or operations to help address any issues specific to each SCS.

5. Public Injection/Injection Related Litter Tracking

Analysis of tracking data for public injection and injection related litter will be analogous to the data analysis methods used by Wood et al. (2004a) in their analysis of public order pre/post Insite implementation. In SAS, descriptive statistics and stratified linear regression

models will be used to compare public injection and injection related litter counts pre and post site implementation. Similar quantitative data analysis methods will be used to analyze secondary data related to public order tracking such as data from the Lookout Emergency Aid Society 'Rig Dig' tracking, City of Surrey, City of Surrey Works Yard, and the Community and Business Persons Survey. Findings from secondary data will be important for triangulation of public order data to further support the validity of the evaluation. As improvements in public order are a key interest of many SCS evaluation stakeholder groups, providing significant evidence demonstrating the impact of the SCS sites on these indicators will be critical.

6. Comment Cards

Comment cards will be analyzed using the same methods as the client/PWUD in the community surveys. Once again, Microsoft Word should suffice given the limited amount of qualitative data that will be examined. Findings from comment cards will help triangulate evidence from the client satisfaction surveys around SCS satisfaction, attendance, and referrals. The open-ended question on the comment card could also provide important insights pertaining to these indicators.

7. Secondary Data Collection

Several evaluation questions rely on the analysis of secondary data to be answered:

- First, the number of overdose deaths occurring in the years pre and post SCS implementation within a 500-metre radius of the sites will be analyzed using data from Coroners' Records. Using SAS, mortality rates will be stratified by proximity to the SCS during the one-year period pre-SCS and post-SCS implementation. Sensitivity analyses similar to those conducted in Marshall et al. (2011) will be conducted to assess

the significance of the findings. Findings from the analysis will help determine the impact of the SCS on overdoses within the 135a and Quibble Creek areas.

- Data for drug-related emergency service calls and attendances as well as drug related ED presentations from within the vicinity of the SCS will be analyzed using similar methods to those used to assess the SCS impact on overdose deaths.
- The BCCDC THN kit reporting data will be retrospectively analyzed at six months post site implementation to see if the distribution of THN kits has increased in the vicinity of the sites.
- Data from intake questionnaires and databases at facilities offering OAT as well as MHSU and Creekside Withdrawal Management Services will be examined at baseline and post site implementation to understand if increases occur in the number of drug users accessing addiction treatment services resulting from referrals from the SCS. Data will be inputted into SAS, and significance testing will determine if the SCS has had any impact on entry into substitution therapies or addiction treatment.
- Secondary data related to public order will be obtained from the City of Surrey Works Yard, City of Surrey, and Lookout Emergency Aid Society. The analysis methods were outlined previously under the public injection/injection related litter analysis section.
- Finally, RCMP crime statistics for charges involving drug trafficking (which is defined to include selling, administering, giving, transferring, transporting, sending, or delivering illicit drugs), assaults and robberies, and vehicle break-ins and vehicle theft in the 500-metre radius of the site will be analyzed to understand the SCS impact on crime in the area. The analysis methods will be similar to those used by Wood et al. (2006b) in their analysis of crime in the vicinity of Insite. Crude monthly crime totals

for one-year period pre SCS and post SCS implementation will be compared using SAS. A t-test will be used to understand if any significant differences are apparent in overall crime as well as each type of crime pre and post site implementation.

4.4 Timeline

Component: Primary Data Collection	Lead	Timeline (months)															
		3pre	2pre	1pre		1	2	3	4	5	6	7	8	9	10	11	12
Conduct pre-implementation walk around using tracking tool to examine injection related litter & public injection	FH staff or RA				Site Implementation												
Administer Community and Business Persons Survey (send survey invite in mail with online link)	FH staff- Amy																
Create Access Database and train staff in database use for ongoing collection	Chris					*Ongoing collection of data in access database*											
Provide each site with comment cards and box to collect submitted feedback	FH staff					*Ongoing collection of client feedback from comment cards*											
Conduct key informant interviews to understand SCS services/changes (conduct interviews, transcribe, analyze findings and produce report)	Rachel																
Client Satisfaction Survey (administer questionnaire, analyze findings, produce report)	Lookout staff, Rachel																
PWUD in Community Satisfaction Survey (administer survey, analyze findings, produce report)	Lookout staff, Rachel																
Component: Secondary Data Collection																	
Collect RCMP crime data (*Data may be collected 12 months pre/12 months post)	FH staff, Arjen				Site Implementation												
Track City of Surrey complaint calls regarding public order (injection related litter and public injection)	FH staff, City of Surrey																
Obtain EHS data on # of emergency calls, attendances, and ED presentations from vicinity of each SCS	Salman & Shovita					*Baseline, weekly data collection*											
Obtain SMH data on ED presentations from vicinity of each SCS	Salman					*Baseline, weekly data collection*											
Obtain Coroner's records or EHS data on the # of OD deaths in vicinity	Salman					*Pre, Baseline, monthly data collection*											
Collect data on # of clients accessing and/or attending OAT, MHSU, & Creekside services	FH staff																
Obtain BCCDC data reporting # of THN kits	FH staff																

4.5 Respondent Burden for Data Collection

Description: Providing an overview of the respondent burden for data collection is part of the utilization focused approach of this evaluation. The evaluation recognizes the time commitment from various groups (especially clinical staff and clients) and this overview provides an opportunity to understand whether these expectations are feasible for respondents.

Respondent Group	Data Collection Requirements	Frequency of Collection	Estimated time to complete (if available)
Program participants	Comment Card Client Satisfaction Survey	Ongoing (optional) 1 month, 6 months	2 minutes 5-10 minutes
People who use drugs (PWUD) in the community	PWUD in the Community Survey	1 month, 6 months	5-10 minutes
Community & Business Persons	Community & Business Persons Survey	1 month pre, 6 months post	5-10 minutes
Program staff	Access database	Ongoing	5 minutes per client visit
Site manager	Key informant interviews	Baseline, 6 months	15 minutes per interview
Fraser Health Staff	Mail link for Community and Business Persons Survey Collect treatment services data from (MHSU, OAT, & Creekside)	Baseline, 6 months Baseline, 6 months	Unknown Unknown
Lookout Staff	Administer Client Satisfaction and PWUD in Community Survey	1 month, 6 months	5-10 minutes
City of Surrey	Complaint call tracking (public injection/related litter)	3 months pre, 6 months post	Unknown
RCMP	Crime data collection from RMS records	12 months pre/post	Unknown
BCCDC	THN kit data (# distributed from SCS)	3 months pre, 6 months post	Unknown
Epidemiologist	EHS data for calls and attendances from SCS Coroner's Data/EHS data on OD deaths SMH data on OD presentations in ED from vicinity of SCS	Baseline, weekly Baseline, monthly Baseline, weekly	Unknown Unknown Unknown

Table 4.3: Respondent burden for data collection

5. Communications Plan

Sharing the evaluation findings with the primary and secondary intended users of the evaluation will be critical. Given the controversial nature of SCS, several stakeholders will have questions and concerns that may be answered by the evaluation findings. Consequently, it is important that FH disseminate these findings in a clear and transparent manner to all stakeholders as well as the general public.

Therefore, a report will be prepared by the Evaluation Specialist to share the results of the evaluation with primary and secondary intended users of the evaluation. A summary of the report (briefing document) will also be developed to ensure key findings from the evaluation are shared in a more concise and accessible way to intended users. Additionally, evaluation findings may be summarized in a presentation to be delivered to FH employees, community members, and other stakeholders. The evaluation results will also be shared on the FH website alongside their existing information on SCS. The website will be an opportune place to include more interactive dissemination methods such as infographics outlining key findings to the public. Finally, the evaluation findings may be communicated in FH press briefings or news releases to stakeholders and the public.

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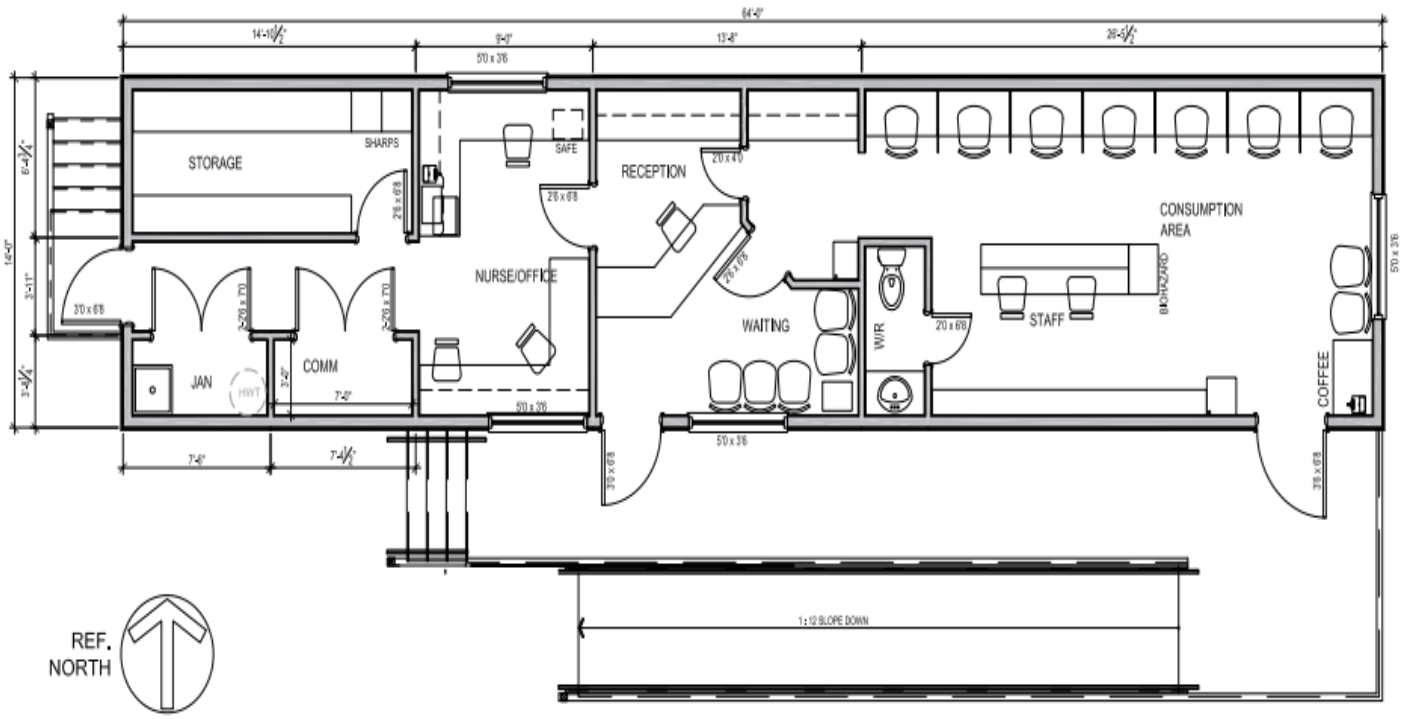
7. Appendices

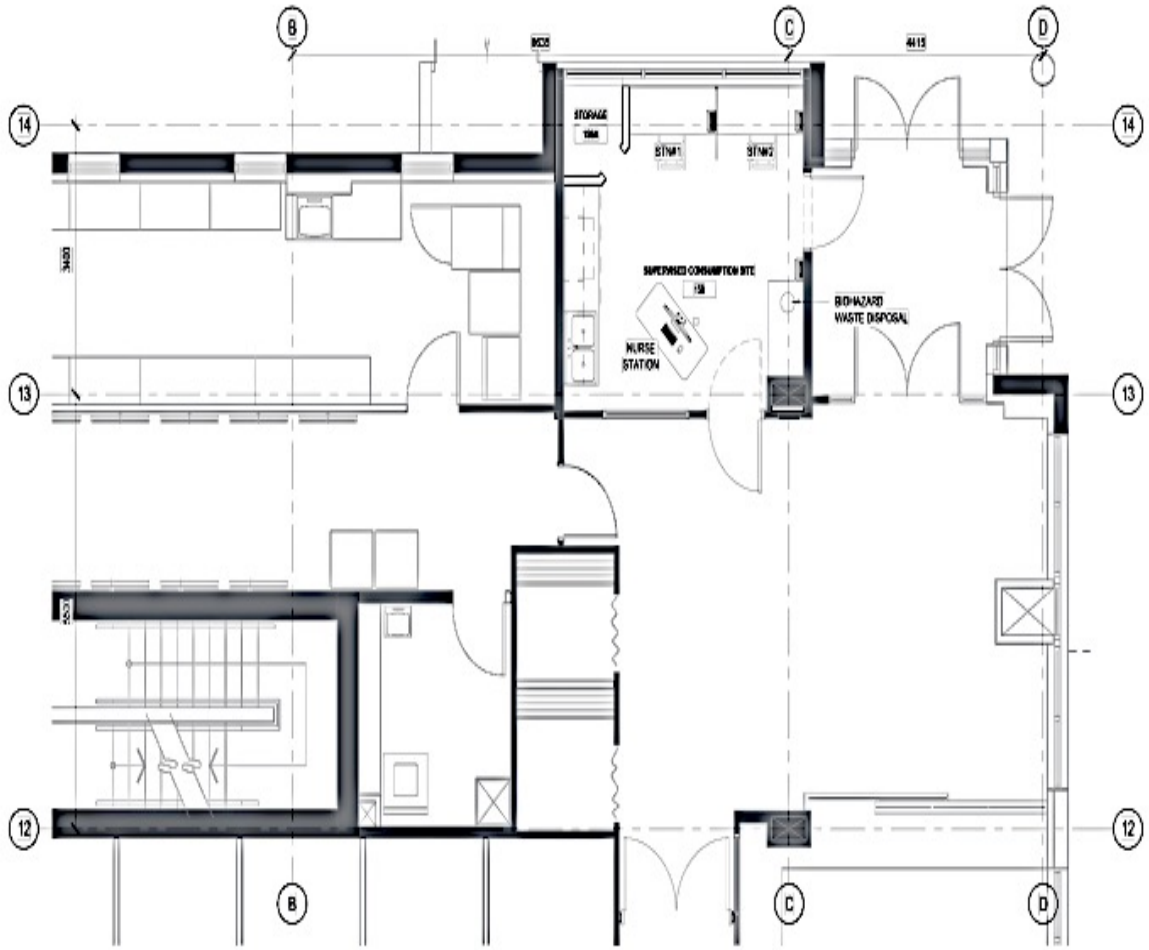
7.1 Appendix A: Floor Plan for 135a SCS

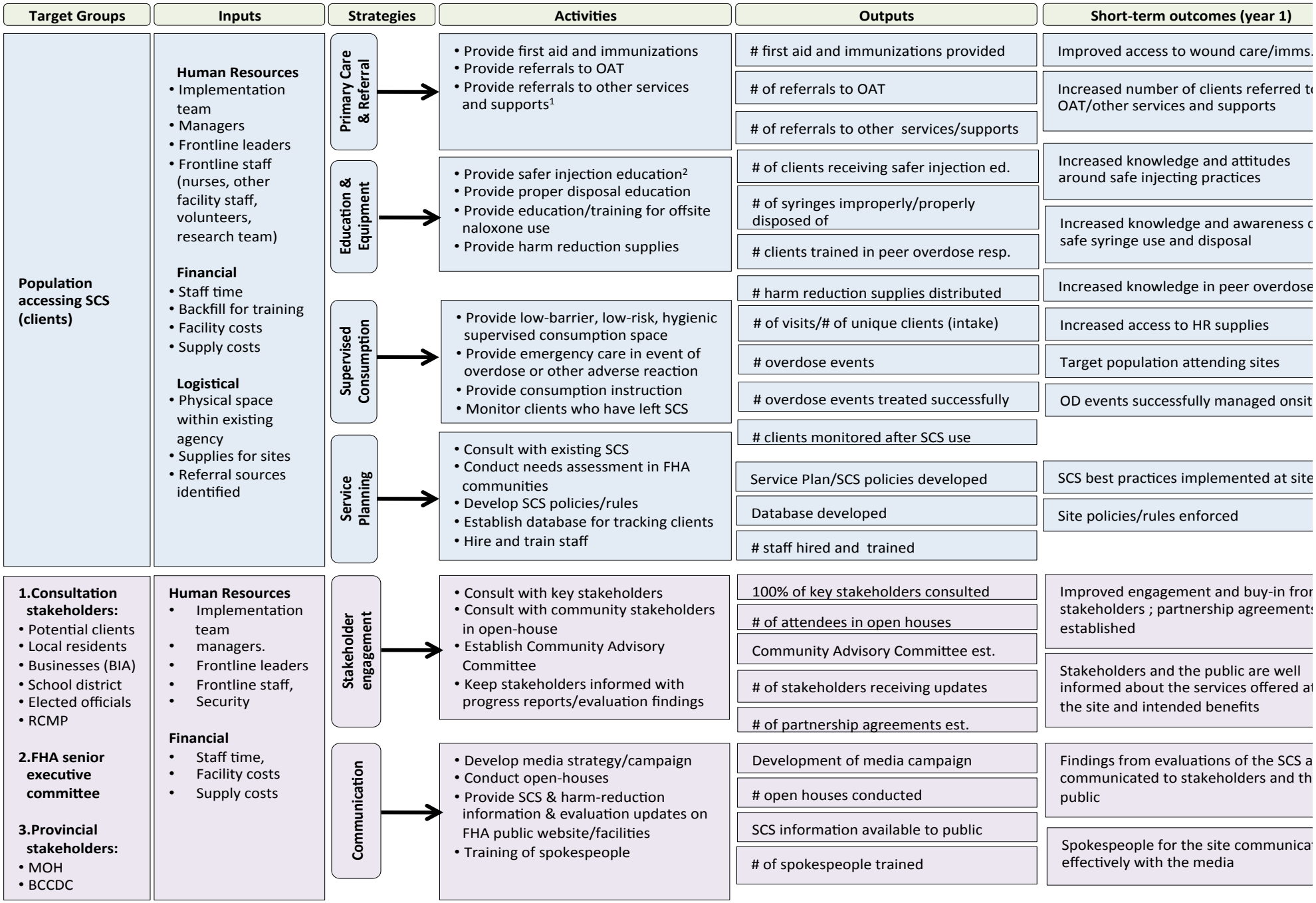
Floor Plan



7.2 Appendix B: Floor Plan for Quibble Creek SAC SCS

Floor Plan





1: Referrals to other services and supports include: withdrawal management services, mental health services, MHSU services
2: Safer consumption education includes: how to use the consumption equipment, proper consumption techniques, overdose prevention and response education (incl. CPR), disposal of drug use equipment
3: Intended outcomes= 1]Prevention of OD deaths 2]Reduction of HIV/HCV risk behaviour 3] Increased initiation of substance use treatment 4]reduction in injection-related litter 5] No increase in drug use or related crime 6]

7.4 Appendix D: Evidence Summary of SCS Evaluation Methodology

Evidence Summary of SCS Evaluation Methodology

Evaluation Question #1: Are the services being provided as intended at the two SCS and adapting to client and community needs? *(process evaluation)*					
Sub-evaluation questions	**Literature**	**Site Location**	**Methodology/Indicators**	**Data Source**	**Feasibility for FH SCS (*)**
i. What is the pattern of client attendance at each SCS?	Tyndall et al. (2006)	Insite, Vancouver	• Used database and handles to track unique client visits over a one year period • Tracked how often individual clients were using the SIF	SIF clients	*
	Kimber et al. (2008)	MSIC, Sydney	• Used surveillance data from SIF, post codes from the needle syringe sharing program and the Australian bureau of statistics to estimate number of IDUs in the area • Then used prevalence estimation methods (capture histories, Poisson estimates) to calculate the percentage of IDUs using the site	IDU population within 2 km radius of site	*
	Dubois-Arber et al. (2008)	Drug Consumption Room (DCR), Geneva, Switzerland	• Recorded injection profiles and DCR use by PWID • Two sources of routine data were used: data collected at the first visit by any new client (entry questionnaire) and data collected on the substances injected at each visit to the DCR • A typology of injection profiles was constructed • Associations between injection characteristics and drug consumption patterns were examined	PWID at DCR	*
ii. Is each SCS providing wound care, vaccinations, and other health services onsite?	Lloyd-Smith et al. (2010)	Insite Vancouver	• Measured factors associated with hospitalization due to cutaneous infection or other cutaneous complications as a result of injection • Measured prevalence among SIF users over a one year period	SEOSI cohort	*
	McNeil et al. (2014)	Dr. Peter Centre (DPC)	• Qualitative interviews conducted with 13 DPC residents between 2010-2011 • Interviewed participants to find out how DPC Residence's model of care (a) shaped healthcare access, (b) influenced healthcare interactions and (c) impacted drug use practices and overall health	13 DPC residents	

Evaluation Question #2: Are SCS services adapting to client and community needs? *(process evaluation)*					
Sub-Evaluation Questions	**Literature**	**Site Location**	**Methodology/Indicators**	**Data Source**	**Feasibility for FH SCS (*)**
i. Have there been any changes to the way SCS services are offered at each site?	*No available evidence found in the literature*				
ii. Are clients satisfied with the services offered at each SCS?	Wood et al. (2004b)	Insite, Vancouver	• Assessed client satisfaction with services offered at the SIF by administering a survey • Clients rated service quality in terms of the 5 SERVQUAL dimensions	SEOSI cohort	*
	Small et al. (2011a)	Insite, Vancouver	• This study involved 50 semi-structured qualitative interviews exploring the IDU perspectives on the design and operation of the SIF • Interview encouraged discussion of the design and operation of the SIF and potential barriers to accessing the SIF	SEOSI cohort	
	Small et al. (2009)	Insite, Vancouver	• 50 semi-structured qualitative interviews were conducted • Interviews examined IDU perspectives regarding the impact of SIF use on access to health and social services. • Specifically, the SIS's impact on access to care and treatment of infections following injection	SEOSI cohort	
	Small et al. (2012)	Insite, Vancouver	• Qualitatively examined the motivations of IDUs to attend Vancouver's SIF • Motivations included: seeking safety, receiving sterile equipment and adequate care in case of overdose	SEOSI cohort	
	Petrar et al. (2007)	Insite, Vancouver	• Evaluated IDU satisfaction with SIS • Participants were surveyed about their experiences and beliefs around the SIF. • Examined injecting behavior (changes in injecting behavior): syringe disposal, public injecting, and safer injecting. • Also examined common factors limiting IDU's use of the SIF: travel to SIF, operating hours, waiting times to access SIF • Finally, examined ways which SIF could be improved from IDU perspective: longer hours, addition of washrooms, and reduced waiting times.	SEOSI cohort	*

iii. Are community members and key stakeholders supportive of each SCS?	DeBeck et al. (2008)	Insite, Vancouver	• Examined impact of local police on SIS attendance • Tracked referrals to SCS by police • Also tracked number of IDUs who had heard about SCS from police	SEOSI cohort	*
	Salmon et al.(2007)	MSIC, Sydney	• Computer assisted telephone interviews were conducted among random samples of residents and business operators in Kings Cross before and after opening of SIF • Data collection included socio-demographic characteristics (of residential respondents only), perceptions of drug-related public amenity issues in the local area, and perceived advantages and disadvantages of MSIC	Local residents: 540–326 business operators: 269–210	*
	Wood et al. (2004b)	Insite, Vancouver	• Conducted a community survey (administered in-person) Recorded perceived changes in the neighbourhood after the SIF's opening from residents and businesses	Street recruited residents and street level businesses	*

Evaluation Question #3: Are the intended benefits of each SCS being recognized? *(Outcome evaluation question)*					
Sub-evaluation Questions	**Literature**	**Site Location**	**Methodology/Indicators**	**Data Source**	**Feasibility for FH SCS (*)**
i. Has there been a decrease in OD deaths among clients?	Kerr et al. (2006b)	Insite, Vancouver	• Examined # overdoses/overdose deaths at site • Examined the drugs used prior to each overdose event and the clinical features of the overdoses that occurred • Examined the interventions undertaken by staff in response to these overdoses.	SEOSI cohort	*
	Kerr et al. (2007b)	Insite, Vancouver	• Semi-structured qualitative interviews • Examined IDU accounts of overdose • Examined perspectives regarding the impact of SIF use on overdose risk and experiences of overdoses • Assessed environmental factors that drive high rates of overdose among IDUs	SEOSI (50 interviews)	

	Marshall et al. (2011)	Insite, Vancouver	• Examined population-based overdose mortality rates for the period before and after the opening of the Vancouver SIF. • Compared overdose fatality rates within an a priori specified 500 m radius of the SIF and for the rest of the city.	Coroner's records	*
	Milloy et al. (2008a)	Insite, Vancouver	• Tracked OD events within last six months from baseline throughout the study period • Evaluated whether the SIF had impact on # of OD events	SEOSI cohort	*
	Milloy et al. (2008b)	Insite, Vancouver	• Estimated the number of fatal overdose deaths by measuring the number of deaths potentially prevented at the SIF (defined as events within the SIF that required the provision of naloxone, a 911 call or an ambulance) • Inputs were derived from counts of overdose deaths by the British Columbia Vital Statistics Agency and non-fatal overdose rates from published estimates.	Data from BC vital statistics agency and data from Insite	
	Van Beek et al. (2004)	MSIC, Sydney	• Examined incidence of OD • Examined # of deaths • Examined characteristics of clients that OD • Examined care of overdoses (oxygen vs. naloxone, support time).	3747 MSIC site users	*
ii. Has there been decreased emergency health care utilization?	Kerr et al. (2006a)	Insite, Vancouver	• Recorded the # of OD events successfully managed within the SIF through the provision of oxygen by staff • Anticipate significant cost savings result from onsite response	SEOSI	*
	Small et al. (2008)	Insite, Vancouver	• Data from 50 in-depth qualitative interviews conducted 2005-2006 • Interviews explored themes relating to SIF use and its impact on managing injection-related infections and the effects of specialized and onsite related care	SEOSI	
	Salmon et al. (2010)	MSIC, Sydney	• Examined the number of ambulance attendances before and after the opening of the SIF • Examined the number of calls to emergency services during the open hours of the SIF in the vicinity of the SIF ($1.5km^2$)	Ambulance records on all patients treated from 1998-2006	*
	Jozaghi, et al. (2013)	Montreal	• Conducted a cost-benefits and cost-effectiveness analysis of reduced HIV/HCV as a result of implementing a SIF in Montreal using mathematical modeling • Determined net average benefit-cost ratio for both HIV/HCV and for each SIF added	Analyzed secondary data from Insite	

	Andresen & Boyd (2010)	Insite, Vancouver	• Used mathematical modeling to estimate the number of new HIV infections and deaths prevented each year by SIF • Included new HIV infections and deaths prevented, in conjunction with estimated lifetime public health care costs of a new HIV infection, and the value of a life, to calculate a portion of the societal benefits of Insite. • This social benefit is weighed against cost of SIF	Analyzed secondary data from Insite	
iii. Has there been a reduction in HIV/HCV risk behavior?	Kerr et al. (2005d)	Insite, Vancouver	• Compared syringe sharing between consistent SIF users with a community-recruited sample of injection drug users • Both groups had similar rates of syringe sharing before the facility opened	VIDUS (431 participants)	
	Stoltz et al. (2007)	Insite, Vancouver	• Consistent SIF users were compared with inconsistent SIF users on self-reported changes in injecting practice behaviours • Behaviours included reuse of syringes, use of sterile water, swabbing injection sites, cooking/filtering drugs, rushed injections, safe syringe disposal and public injecting	SEOSI cohort	*
	Salmon et al. (2009)	MSIC, Sydney	• Measured how many IDUs had been tested for HIV compared to other Australian cohorts who were not attending SIF • Used self-reported prevalence of HIV testing and associated factors among cohort between 2001 and 2007	MSIC users (exhaustive population)	
	Milloy et al. (2009)	Insite, Vancouver	• Examined the impact of Insite on syringe sharing • Used data from all available peer-reviewed estimates of syringe sharing at Insite to construct a random-effects meta-analysis model to produce a pooled estimate of the relationship between SIF use and syringe sharing.	Findings from relevant studies	
iv. Has there been increased interest/initiation of accessing detoxification services or addiction treatment (including OAT) as a result of referrals from	DeBeck et al. (2010)	Insite, Vancouver	• Administered questionnaire at baseline and subsequent follow-up visits • Examined role of SIF in entry into detox program and injection cessation (a period of at least six months without injecting)	SEOSI cohort	*
	Wood et al. (2006a)	Insite, Vancouver	• Examined correlation between SIF use and entry into detox program over 2 year period • Frequency of SIF attendance and characteristics of IDU examined	SEOSI cohort	*

SCS sites?	Wood et al. (2007)	Insite, Vancouver	• Conducted retrospective and prospective database linkages with residential detoxification facilities and used generalized estimating equation (GEE) methods to examine the rate of detoxification service use among SIF participant • Analyzed the year before versus the year after the SIF opened	SEOSI cohort	
	McNeil et al. (2014)	Dr. Peter Centre (DPC)	• Qualitative interviews conducted with 13 DPC residents between 2010-2011 • Interviewed participants to find out how DPC Residence's model of care (a) shaped healthcare access, (b) influenced healthcare interactions and (c) impacted drug use practices and overall health	13 DPC residents	*
v. Has the amount of injection-related litter in the area immediately surrounding the SCS sites decreased?	Wood et al. (2004a)	Insite, Vancouver	• Measured public order indicators (including injection related litter) within defined times of the week pre/post site implementation. • Data collection involved walking through the study zone in the same pattern. • Measures of discarded syringes, injection-related litter, and public injection drug use are all measured prospectively • Also measured # of used needles discarded in public disposal boxes	Surrounding area of SIF	*
vi. Has the amount of public injection in the area immediately surrounding the SCS sites decreased?	Wood et al. (2004a)	Insite, Vancouver	• Measured specified public order indicators within an a priori defined times of the week. • Data collection involved walking through the study zone in the same pattern. • # of discarded syringes, injection-related litter, and public injection drug use were all measured prospectively.	Surrounding area of SIF	*
	McKnight et al. (2007)	Insite, Vancouver	• Examined characteristics and factors associated with public injection including frequency of SIF use and the impact on public injection	SEOSI cohort	*
vii. Has the amount of related crime remained the same in the vicinity of each SCS?	Kerr et al. (2006b)	Insite, Vancouver	• Drug use behaviours were observed in the one-year period before the opening of Insite and in the one-year period after. • Drug use behaviours included rates of relapse into injection, drug use among former users, and the cessation of injection drug use among current users. • Also evaluated access to palliative and supportive care services, acceptability of drug use/relationship with staff, and whether or not environmental supports decreased drug related risks.	VIDUS (871 participants)	

	Kerr et al. (2007c)	Insite, Vancouver	• Evaluative observational study examining SIS's impact on initiation and encouragement of injection drug use • Compared non-SIS using cohort's # of initiations with SIS using cohort # of initiations	SEOSI cohort	*
	Wood et al. (2006b)	Insite, Vancouver	• Used data from the VPD on drug trafficking, assaults, robberies, vehicle break-ins, and thefts in the following areas: DTES, Victory Square, Chinatown, Gastown and Strathcona • Compared crime rates from the years before and after Insite opened	VPD crime data for areas in site vicinity	*
	Fitzgerald et al. (2010)	MSIC, Sydney	• Impact of the SIS opening on local crime (King Cross area) compared to the rest of the city • Longitudinal retrospective study over 11 year study period	Computerized police reports	*

7.5 Appendix E: Evaluation Matrix

Evaluation Question #1: Are the services being provided as intended at the two SCS and adapting to client and community needs?					
Evaluation Sub-Questions	**Indicators**	**Data Sources**	**Data Collection Methods**	**Timeframe**	**Responsibility**
i. What is the pattern of client attendance at each SCS?	# of client visits (total)	SCS clients	Access database or clinical notes (paper records)	Ongoing	SCS staff
	# of unique clients (frequency of use)	SCS clients	Access database or clinical notes (paper records)	Ongoing	SCS staff
	Demographic of clients accessing SCS (age, gender, ethnicity)	SCS clients	Access database or clinical notes (paper records)	Ongoing	SCS staff
	Services accessed by clients	SCS clients	Access database or clinical notes (paper records)	Ongoing	SCS staff
ii. Is each SCS providing wound care, vaccinations, and other health services onsite?	# of clients receiving wound care, vaccination, and other health services	SCS clients	Access database or clinical notes	Baseline, 6 months, 1 year	SCS staff
Evaluation Question #2: Are SCS services adapting to client and community needs?					
Evaluation Sub-Questions	**Indicators**	**Data Sources**	**Data Collection Methods**	**Timeframe**	**Responsibility**
i. Have there been any changes to the way SCS services are offered at each site?	Changes to the way SCS services are offered	Site Manager	Key informant interviews	1 month, 6 months	Evaluator
	# of services offered (have services been added/removed?)	Site Manager	Key informant interviews	1 month, 6 months	Evaluator
	What are the similarities and differences between sites, Why?	Site Manager	Key informant interviews	1 month, 6 months	Evaluator
ii. Are clients satisfied with the services offered at each SCS?	% of clients that report being satisfied with services offered at SCS	SCS clients	Client satisfaction survey and/or comment cards	1 month, 6 months	Evaluator, Lookout Staff

	Satisfaction of clients in community	Clients in community (attend SCS at least once)	PWUD in the community satisfaction survey	1 month, 6 months	Evaluator, Lookout Staff
iii. Are community members and key stakeholders supportive of each SCS?	% of community members support SCS (within 500 m radius)	Community members within 500 m radius of each site	Online survey (link mailed out)	1 month pre, 6 months post	Fraser Health staff, Project Manager
	% of businesses/community organizations support SCS (within 500 m radius)	Business Persons within 500 m radius of each site	Online survey (link mailed out)	1 month pre, 6 months post	Fraser Health staff, Project Manager
	# of referrals from stakeholders to SCS	SCS clients	Client satisfaction/PWUD in the community survey	1 month, 6 months	Evaluator, Lookout Staff
			Comment cards	Ongoing	Evaluator, SCS Staff
Evaluation Question #3: Are the intended benefits of each SCS being recognized?					
Evaluation Sub-Questions	**Indicators**	**Data Sources**	**Data Collection Methods**	**Timeframe**	**Responsibility**
i. Has there been a decrease in OD deaths among PWUD in the vicinity of the sites?	# of OD deaths in vicinity before and after site opening (500m)	PWUD in vicinity	Coroner's Records or Emergency Services (Ambulance, Fire, RCMP records)	Pre, baseline, monthly	Epidemiologist
	# of OD events successfully managed onsite	SCS clients	Access database, clinical notes	Ongoing	SCS staff
ii. Has there been decreased emergency health care utilization among PWUD in the vicinity of the sites?	# of emergency service calls and attendances	EHS, fire, RCMP	Access database and/or EHS, fire, RCMP records of attendances	Pre, baseline, weekly	Epidemiologist, Medical Health Officer

	# of ED presentations before and after SCS opening within vicinity (500 m radius)	EHS data, fire, RCMP	EHS, fire, RCMP records of transport to ED or SMH records of overdose ED presentations	Pre, baseline, weekly	Epidemiologist
iii. Has there been a reduction in HIV/HCV risk behaviour among clients?	# of harm reduction supplies provided onsite	SCS staff	Access database	6 months	SCS Staff
	# of THN kits provided onsite	BCCDC data	BCCDC reporting	6 months, retrospective data collection	Epidemiologist
	# clients receiving safe injection education	SCS staff	Access database, clinical notes	Ongoing	SCS staff
		SCS clients	Client Satisfaction Survey PWUD in Community Survey	1 month, 6 months	Evaluator, Lookout Staff
	# of clients report needle sharing	SCS clients	Client satisfaction survey	1 month, 6 months	Evaluator, Lookout Staff
iv. Has there been increased interest/initiation of accessing OAT and other treatment services as a result of referrals from SCS sites?	# of clients accessing OAT	SCS clients	OAT facilities data	Baseline, 6 months	OAT facility staff
			Access database	Baseline, 6months	SCS staff
	# of clients who are accessing OAT actually starting OAT	SCS clients	OAT facilities	Baseline, 6 months	OAT facility staff
			Access database	Baseline, 6 months	SCS staff
	# of clients referred to withdrawal management services, mental health services, MHSU services	SCS clients	Access databases	Baseline, 6 months	SCS staff

	# of clients accessing withdrawal management services, mental health services, and MHSU services	SCS clients	MHSU & Creekside databases Access database	Baseline, 6 months	MHSU, Creekside, and/or SCS staff
v. Has the amount of injection related litter in the area immediately surrounding the SCS decreased?	# of improperly discarded syringes (and injection related litter)	Surveillance data	Public Injection/Injection Related litter tracking tool	6 weeks pre, 6 weeks post	FH staff
	# of complaint calls related to injection litter pre/post	Complaint calls to City Works Yard	City Works Yard (tracking call-outs/records)	6 weeks pre, 6 weeks post	Evaluator
		Community and Business Persons within 500 m radius of each site	Online survey (link mailed out)	1 month pre, 6 months post	Project Manager
vi. Has there been a reduction in public injection behaviour?	# of people publically injecting	Surveillance data	Public Injection/Injection Related litter tracking tool	6 weeks pre, 6 weeks post	Mental Health Workers
	# of complaint calls related to public injection	City of Surrey	City of Surrey (may need to manually review cases)	6 weeks pre, 6 weeks post	Evaluator
		Community and Business Persons within 500 m radius of each site	Online survey (link mailed out)	1 month pre, 6 months post	Project Manager
vii. Hast the amount of related crime remained the same in the vicinity of each SCS?	# of crimes committed in vicinity	RCMP records	RCMP Records Management System (RMS) data. → Need to define vicinity and crimes to include (VPD included drug trafficking, assaults, robberies, theft and thefts from vehicle).	12 months pre site opening/12 months post	Evaluator

7.6 Appendix F: Data Collection Tools

7.6.1 Client Satisfaction Survey (1 month post)

We would like to learn more about your thoughts on the Supervised Consumption Sites (SCS). Your answers will help us understand how we can improve the services at the SCS. The survey should take 5-10 minutes to complete and you can stop the survey at any time. Thank you for your feedback!

Handle: _____

1. **How often do you use the site to consume drugs?**
   - ☐ More than once a day
   - ☐ Once a day
   - ☐ A few times a week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ Once a month
   - ☐ Less than once a month
   - ☐ Have not used the site in the past month (why?) _____

2. **How did you find out about the site?**
   - ☐ Friend or acquaintance
   - ☐ Dealer
   - ☐ Poster
   - ☐ Media
   - ☐ Community organization
   - ☐ Outreach worker
   - ☐ Police
   - ☐ Other, please specify… _____

3. **How often in the last six months have you used a needle after someone else has already used it?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

4. **How often in the last six months has someone else used a needle that you have already used?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

5. **Do any of the following features of the SCS affect how often you use at the site?**
   a) **Travel time to get to the site?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   b) **Operating hours of SCS?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   c) **Waiting time to get into consumption room?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   d) **The rules and regulations of the site?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

6. **How would you rate the quality of services offered at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

7. **How would you rate the facilities and equipment at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

8. **Do you think site staff are caring and accepting of people who use drugs?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

9. **Have you ever received safer consumption advice or education at the site?**
   - ☐ Yes
   - ☐ No

10. **Have you ever been referred from the SCS to another medical or social service?**
   - ☐ Yes (Specify) _____
   - ☐ No

11. **What is your age?**
   - ☐ 19 years or younger
   - ☐ 20-29 years old
   - ☐ 30-39 years old
   - ☐ 40-49 years old
   - ☐ 50-59 years old
   - ☐ 60 years or older

12. **What gender do you identify as?**
   - ☐ Female
   - ☐ Male
   - ☐ Transgender
   - ☐ Other, please specify…

     _____

13. **Is there anything else you would like to tell us about your experience(s) at the site?**

7.6.2 Client Satisfaction Survey (6 months post)

We would like to learn more about your thoughts on the Supervised Consumption Sites (SCS). Your answers will help us understand how we can improve the services at the SCS. The survey should take 5-10 minutes to complete and you can stop the survey at any time. Thank you for your feedback!

Handle: _____

1. **How often do you use the site to consume drugs?**
   - ☐ More than once a day
   - ☐ Once a day
   - ☐ A few times a week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ Once a month
   - ☐ Less than once a month
   - ☐ Only used it once
   - ☐ Have not used the site in the past six months (why?) _____

2. **How did you find out about the site?**
   - ☐ Friend or acquaintance
   - ☐ Dealer
   - ☐ Poster
   - ☐ Media
   - ☐ Community organization
   - ☐ Outreach worker
   - ☐ Police
   - ☐ Other, please specify… _____

3. **How often in the last six months have you used a needle after someone else has already used it?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

4. **How often in the last six months has someone else used a needle that you have already used?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

5. **Do any of the following features of the SCS affect how often you use at the site?**

   a) **Travel time to get to the site?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

   b) **Operating hours of SCS?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

   c) **Waiting time to get into consumption room?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

   d) **The rules and regulations of the site?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

6. **How would you rate the quality of services offered at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

7. **How would you rate the facilities and equipment at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

8. Do you think site staff are caring and accepting of people who use drugs?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Occasionally
- ☐ Never

9. Have you ever received safer consumption advice or education at the site?

- ☐ Yes
- ☐ No

10. Have you ever been referred from the SCS to another medical or social service?

- ☐ Yes (Specify) _____
- ☐ No

11. What is your age?

- ☐ 19 years or younger
- ☐ 20-29 years old
- ☐ 30-39 years old
- ☐ 40-49 years old
- ☐ 50-59 years old
- ☐ 60 years or older

12. What gender do you identify as?

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Other, please specify…

_____

13. Is there anything else you would like to tell us about your experience(s) at the site?

7.6.3 Persons Who Use Drugs in the Community Survey (1 month post)

We would like to learn more about your thoughts on the Supervised Consumption Sites (SCS). Your answers will help us understand how we can improve the services at the SCS. The survey should take 5-10 minutes to complete and you can stop the survey at any time. Thank you for your feedback!

Handle (if applicable): _____

1. **Which site have you attended in the past? (Check all that apply)**
   - ☐ 135a Portable SCS
   - ☐ Quibble Creek Sobering & Assessment Centre SCS
   - ☐ I have not gone to either SCS

2. **How often do you use the site to consume drugs?**
   - ☐ More than once a day
   - ☐ Once a day
   - ☐ A few times a week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ Once a month
   - ☐ Less than once a month
   - ☐ Have not used the site in the past month (why?) _____

3. **Has anyone recommended the SCS to you?**
   - ☐ Friend or acquaintance
   - ☐ Dealer
   - ☐ Poster
   - ☐ Media
   - ☐ Community organization
   - ☐ Outreach worker
   - ☐ Police
   - ☐ Other, please specify… _____

4. **How often in the last six months have you used a needle after someone else has already used it?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

5. **How often in the last six months has someone else used a needle that you have already used?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

6. **Do any of the following features of the SCS prevent you from going to a site?**
   a) **Travel time to get to the site?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never
   b) **Operating hours of SCS?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   c) **Waiting time to get into the consumption room?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   d) **The rules and regulations of the site?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

7. **What do you think about the quality of services offered at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

8. **What do you think about the facilities and equipment at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

9. **Do you think site staff are caring and accepting of people who use drugs?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

10. **If you have been to the site, have you ever received safer consumption advice or education at the site?**
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable

11. **If you have been to the site, have you ever been referred from the SCS to another medical or social service?**
   - ☐ Yes (Specify) _____
   - ☐ No
   - ☐ Not applicable

12. **What is your age?**
   - ☐ 19 years or younger
   - ☐ 20-29 years old
   - ☐ 30-39 years old
   - ☐ 40-49 years old
   - ☐ 50-59 years old
   - ☐ 60 years or older

13. **What gender do you identify as?**
   - ☐ Female
   - ☐ Male
   - ☐ Transgender
   - ☐ Other, please specify…

     _____

14. **Is there anything else you would like to tell us about the site?**

7.6.4 Persons Who Use Drugs in the Community Survey (6 months post)

We would like to learn more about your thoughts on the Supervised Consumption Sites (SCS). Your answers will help us understand how we can improve the services at the SCS. The survey should take 5-10 minutes to complete and you can stop the survey at any time. Thank you for your feedback!

Handle (if applicable): _____

1. **Which site have you attended in the past? (Check all that apply)**
   - ☐ 135a Portable SCS
   - ☐ Quibble Creek Sobering & Assessment Centre SCS
   - ☐ I have not gone to either SCS

2. **How often did you use the site to consume drugs?**
   - ☐ More than once a day
   - ☐ Once a day
   - ☐ A few times a week
   - ☐ Once a week
   - ☐ A few times a month
   - ☐ Once a month
   - ☐ Less than once a month
   - ☐ Only used it once
   - ☐ Never (why?) _____

3. **Has anyone recommended the SCS to you?**
   - ☐ Friend or acquaintance
   - ☐ Dealer
   - ☐ Poster
   - ☐ Media
   - ☐ Community organization
   - ☐ Outreach worker
   - ☐ Police
   - ☐ Other, please specify… _____

4. **How often in the last six months have you used a needle after someone else has already used it?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

5. **How often in the last six months has someone else used a needle that you have already used?**
   - ☐ Always (100% of the time)
   - ☐ Usually (over 75% of the time)
   - ☐ Sometimes (26% to 74% of the time)
   - ☐ Occasionally (Under 25% of the time)
   - ☐ Never (0% of the time)

6. **Do any of the following features of the SCS prevent you from going to a site?**
   a) **Travel time to get to the site?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   b) **Operating hours of SCS?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   c) **Waiting time to get into the consumption room?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

   d) **The rules and regulations of the site?**
      - ☐ Always
      - ☐ Usually
      - ☐ Sometimes
      - ☐ Occasionally
      - ☐ Never

7. **What do you think about the quality of services offered at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

8. **What do you think about the facilities and equipment at the site?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

9. **Do you think site staff are caring and accepting of people who use drugs?**
   - ☐ Always
   - ☐ Usually
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

10. **If you have been to the site, have you ever received safer consumption advice or education at the site?**
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable

11. **If you have been to the site, have you ever been referred from the SCS to another medical or social service?**
   - ☐ Yes (Specify) _____
   - ☐ No
   - ☐ Not applicable

12. **What is your age?**
   - ☐ 19 years or younger
   - ☐ 20-29 years old
   - ☐ 30-39 years old
   - ☐ 40-49 years old
   - ☐ 50-59 years old
   - ☐ 60 years or older

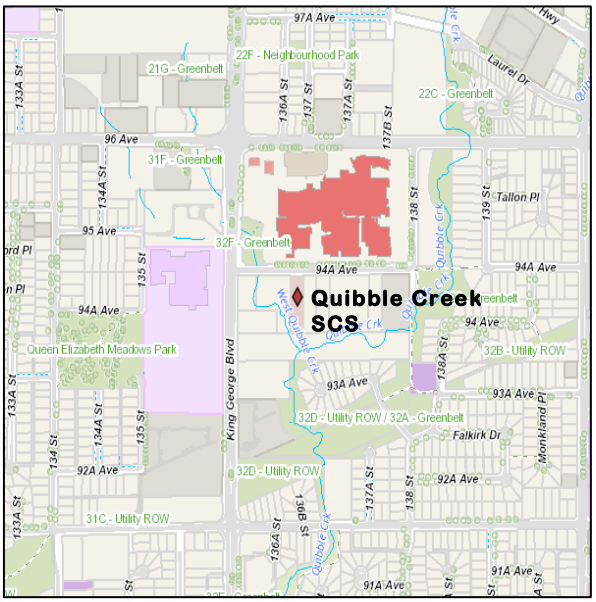
13. **What gender do you identify as?**
   - ☐ Female
   - ☐ Male
   - ☐ Transgender
   - ☐ Other, please specify…

     _____

14. **Is there anything else you would like to tell us about the site?**

7.6.5 Community and Business Persons Survey (1 month pre)

We would like to learn more about the impact of the Supervised Consumption Site (SCS) being implemented near your home or business. We are asking all residents or business persons within a 500 metre radius of an SCS to complete this survey. Your answers will help us understand community concerns and/or satisfaction with the site. The survey should only take 5 minutes and you can stop the survey at any time. Thank you for your feedback!



1. **Based on the maps above, which SCS is closest to your business or residence?**
   - ☐ 135a Portable SCS
   - ☐ Quibble Creek Sobering & Assessment Centre SCS

2. **Are you a business person or resident in the area?**
   - ☐ Business person
   - ☐ Resident

3. **How long have you resided or operated a business in the area?**
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-4 years
   - ☐ 5 or more years

4. **What is your age?**
   - ☐ Under 19 years old
   - ☐ 20-29 years old
   - ☐ 30-39 years old
   - ☐ 40-49 years old
   - ☐ 50-59 years old
   - ☐ 60-69 years old
   - ☐ 70-79 years old
   - ☐ 80 years or older

5. **How supportive are you of an SCS being implemented?**
   - ☐ Very unsupportive
   - ☐ Unsupportive
   - ☐ Neither supportive or unsupportive
   - ☐ Supportive
   - ☐ Very supportive

6. **What kind of impact do you expect the SCS will have?**
   - ☐ Very negative impact
   - ☐ Somewhat negative impact
   - ☐ No impact
   - ☐ Somewhat positive impact
   - ☐ Very positive impact

7. **When did you last see someone using injection drugs in a public place in the area shown on the map?**
   - ☐ Within the last day
   - ☐ Within the last week
   - ☐ Within the last month
   - ☐ Within the last six months
   - ☐ Within the last year
   - ☐ Never

8. **When did you last see a discarded syringe in the area shown on the map?**
   - ☐ Within the last day
   - ☐ Within the last week
   - ☐ Within the last month
   - ☐ Within the last six months
   - ☐ Within the last year
   - ☐ Never

9. **Based on research, the following are some anticipated benefits of implementing SCS sites. What do you think is the likelihood of each of these benefits occurring in the vicinity of the SCS you are closest to?**

   a. **Fewer fatal drug overdoses**
      - ☐ Extremely likely
      - ☐ Likely
      - ☐ Neutral
      - ☐ Unlikely
      - ☐ Extremely unlikely

   b. **Reductions in emergency health care usages (cost savings)**
      - ☐ Extremely likely
      - ☐ Likely
      - ☐ Neutral
      - ☐ Unlikely
      - ☐ Extremely unlikely

c. Decreased number of drug users with HIV/HCV

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

d. Increased number of drug users accessing treatment

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

e. Less injection related litter in the neighbourhood

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

f. Less public injection in the neighbourhood

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

g. Are there any other advantages to implementing an SCS you can think of? Please specify… _____

10. Based on research, the following are some common concerns with implementing SCS sites. What do you think is the likelihood of each of these concerns occurring in the vicinity of the SCS you are closest to?

a. Drug users may be attracted to the area

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

b. Drug dealers may be attracted to the area

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

c. Drug use may be encouraged in the area

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

d. Crime may increase in the area

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

e. Public injecting or discarded syringes may be more common

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

f. The SCS may not address the drug problem

- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

g. I have no concerns about the SCS

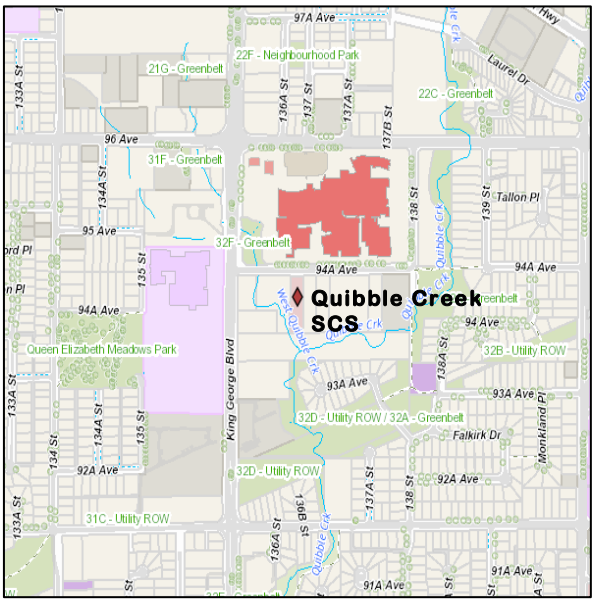
- ☐ Extremely likely
- ☐ Likely
- ☐ Neutral
- ☐ Unlikely
- ☐ Extremely unlikely

h. **Are there any other concerns with implementing an SCS you can think of? Please specify…** _____

11. **Would you like to share any other thoughts with us about the SCS being implemented in your neighbourhood?**

7.6.6 Community and Business Persons Survey (6 months post)

We would like to learn more about the impact of the Supervised Consumption Site (SCS) being implemented near your home or business. We are asking all residents or business persons within a 500 metre radius of an SCS to complete this survey. Your answers will help us understand community concerns and/or satisfaction with the site. The survey should only take 5 minutes and you can stop the survey at any time. Thank you for your feedback!



1. **Based on the maps above, which SCS is closest to your business or residence?**
   - ☐ 135a Portable SCS
   - ☐ Quibble Creek Sobering & Assessment Centre SCS

2. **Are you a business person or resident in the area?**
   - ☐ Business person
   - ☐ Resident

3. **How long have you resided or operated a business in the area?**
   - ☐ Less than 1 year
   - ☐ 1-2 years
   - ☐ 3-4 years
   - ☐ 5 or more years

4. **What is your age?**
   - ☐ Under 19 years old
   - ☐ 20-29 years old
   - ☐ 30-39 years old
   - ☐ 40-49 years old
   - ☐ 50-59 years old
   - ☐ 60-69 years old
   - ☐ 70-79 years old
   - ☐ 80 years or older

5. **How supportive are you of the SCS in your area?**
   - ☐ Very unsupportive

- ☐ Unsupportive
- ☐ Neither supportive or unsupportive
- ☐ Supportive
- ☐ Very supportive

6. **What kind of impact do you think the SCS has had?**
   - ☐ Very negative impact
   - ☐ Somewhat negative impact
   - ☐ No impact
   - ☐ Somewhat positive impact
   - ☐ Very positive impact

7. **When did you last see someone using injection drugs in a public place in the area shown on the map?**
   - ☐ Within the last day
   - ☐ Within the last week
   - ☐ Within the last month
   - ☐ Within the last six months
   - ☐ Within the last year
   - ☐ Never

8. **When did you last see a discarded syringe in the area shown on the map?**
   - ☐ Within the last day
   - ☐ Within the last week
   - ☐ Within the last month
   - ☐ Within the last six months
   - ☐ Within the last year
   - ☐ Never

9. **Based on research, the following are some anticipated benefits of implementing SCS sites. Do you think that any of these benefits have occurred as a result of the services provided at the SCS you are closest to?**

   a. Fewer fatal drug overdoses
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neither agree or disagree
   - ☐ Disagree
   - ☐ Strongly disagree

   b. Reductions in emergency health care usages (cost savings)
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neither agree or disagree
   - ☐ Disagree
   - ☐ Strongly disagree

   c. Decreased number of drug users with HIV/HCV
   - ☐ Strongly agree

- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

d. Increased number of drug users accessing treatment

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

e. Less injection related litter in the neighbourhood

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

f. Less public injection in the neighbourhood

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

g. Are there any other advantages to implementing an SCS you can think of? Please specify… _____

10. Based on research, the following are some common concerns with SCS sites. Do you think that any of these concerns have occurred as a result of the services provided at the SCS you are closest to?

a. Drug users are attracted to the area

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

b. Drug dealers are attracted to the area

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

c. Drug use is encouraged in the area

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

d. Crime has increased in the area

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

e. Public injecting or discarded syringes are more common

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

f. The SCS does not address the drug problem

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

g. I have no concerns about the SCS

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree or disagree
- ☐ Disagree
- ☐ Strongly disagree

h. **Are there any other concerns with implementing an SCS you can think of? Please specify…** _____

11. **Would you like to share any other thoughts with us about the SCS being implemented in your neighbourhood?**

7.6.7 Key Informant Interview Guide

Participants: Site Manager(s)
Administered: 1 month, 6 months
Interview Preamble: Thank you for agreeing to assist us with the evaluation of the SCS. As a reminder, this interview is being conducted to help us find out more about how the SCS services are being offered and any changes that have occurred since the SCS opened. This discussion should last no longer than 20 minutes. I also want to remind you that you can always skip answering a question and you can end the interview at any time. I may be taking notes throughout the interview to summarize your feedback. If you are ready, we will get started…

Interview Guide:

1. From your perspective, are the sites operating as intended? Why or why not?
   - Are the sites achieving their intended outcomes?
   - Intended outcomes= clients satisfied, community supportive, OD deaths reduced, HIV/HCV risk behaviour reduced, reduced emergency health care usage, increased referrals/access to treatment, decreased public injection/injection related litter, and no increases in crime.

2. What are some of the main strengths with how the sites operate?
   - What are the main strengths specific to 135A? QC SAC?

3. What are some of the main challenges with how the sites operate?
   - For instance, are there any challenges with location, co-location with ____ (RCMP trailer, SMH, etc.), staff, staffing profile, community members, etc.
   - What are the main challenges specific to QC SAC? 135a?

4. Since the site opened, have there been any changes to the way existing services are offered? Could you please describe these changes?
   - Why was _____ service changed?
   - In your opinion, has the change made the service better or worse?
   - Are there any services that you think should be changed? Why?

5. Since the site opened, have there been any services that have been added or removed? Could you please describe these services?
   - Why was _____ service added or removed?
   - In your opinion, has the addition/removal of this service(s) resulted in better outcomes at the SCS?
   - Are there any other services that you would like to see added or removed? Why?

6. Is there anything else you think I should know?

This concludes our discussion. I would like to thank you for taking the time to assist us with the evaluation of the SCS.

7.6.8 Public Injection/Injection Related Litter Study Zone Map for 135a SCS

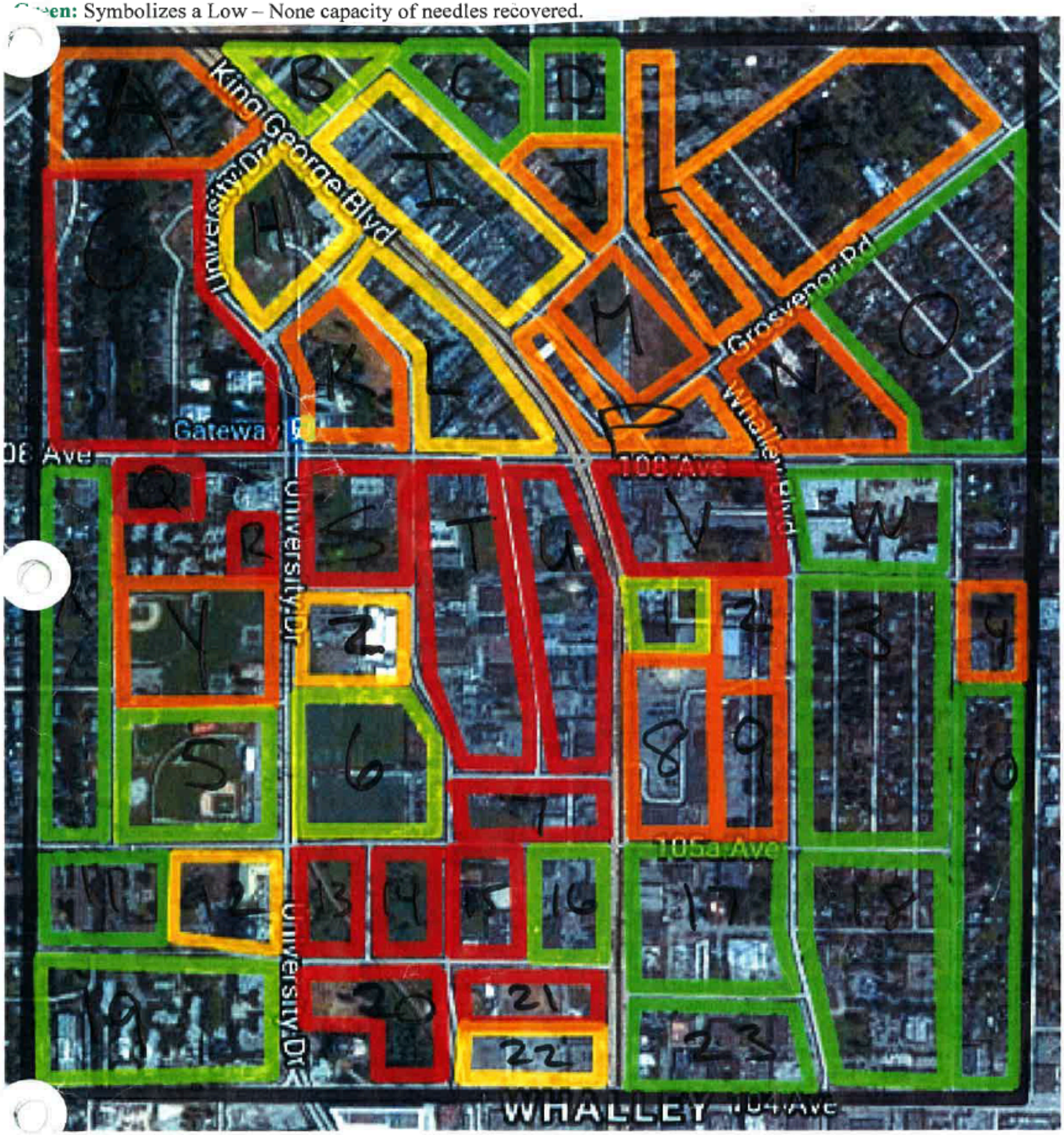
Legend:

Red: symbolizes a High capacity of needles recovered.

Orange: Symbolizes a High – Moderate capacity of needles recovered.

Yellow: Symbolizes a Moderate – Low capacity of needles recovered.

Green: Symbolizes a Low – None capacity of needles recovered.



Rig Dig Recovery Stats:

7.6.10 Public Injection/Injection Related Litter Tracking Tools

PUBLIC INJECTION TRACKING

Date (M/D/Y)**:**	**Completed by:**
Time (provide range of time, i.e. 9am-12pm):	**Site** (135a or QC SAC Zone)**:**

Date	# Public Injection Events	# of people injecting	Zone	Description

INJECTION RELATED LITTER TRACKING

Date (M/D/Y)**:**	**Completed by:**
Time (provide range of time, i.e. 9am-12pm):	**Site** (135a or QC SAC Zone)**:**

Date	# of discarded syringes	# injection related litter	Zone	Description

7.6.11 Comment Cards

WE WOULD LIKE TO HEAR FROM YOU!

For each question below, circle the number
to the right that best fits or provide a written response

Feedback Question	Scale				
	Poor	Good			Excellent
How would you rate the services offered here?	1	2	3	4	5
How would you rate the friendliness of our staff?	1	2	3	4	5
What do you think about the location of this site?	1	2	3	4	5
What do you think of the hours we are open?	1	2	3	4	5
How would you rate your safety and security at the site?	1	2	3	4	5
How many times have you attended this site in the past year?	1 time	2 times	3 times	4 times	5+ times
How did you hear about us?					
Is there anything else you would like to tell us about your experiences at the site? *(Please feel free to write on the back of the card if you need more room)*					

7.7 Appendix G: Critical Reflection

This capstone project was a very rewarding experience for me as I approach the end of my MPH program. During this project, I was able to apply a range of knowledge and skills I have learned throughout the MPH while producing a tool for a large health care organization. I was especially grateful to have had the opportunity to work at Fraser Health while completing my project. My proximity to people involved in the SCS implementation/evaluation allowed for greater collaboration with the organization. As I am hoping to work in the field of program planning and evaluation upon graduating from the MPH, I was thrilled to have had the opportunity to enhance my evaluation skills while completing this project. Planning the evaluation closely with the FH Evaluation Specialist, Rachel Douglas, allowed me to learn various practical evaluation strategies. Working with my supervisor, Dr. Small, also allowed me to expand my knowledge of research methodologies, people who use drugs, and harm reduction approaches. Finally, as the primary person developing the evaluation plan, I conducted a rigorous literature review and created an evidence summary, logic model, evaluation matrix, and several data collection strategies. By completing this comprehensive evaluation plan, I have certainly developed expertise in the area of program evaluation.

I am pleased that this project will be used by FH to guide their evaluation and could help positively impact population health in the Fraser Region. By developing the evaluation plan with FH directly, I am certain that the product aligns closely with their evaluation needs and will allow for greater understanding of the effectiveness of SCS programs. Ultimately, my hope is that FH will use the results of this evaluation to improve the services and conditions for PWUD. Finally, I expect that this evaluation

plan will be useful for other health care organizations who might be implementing SCS sites in their communities. For instance, other health authorities have contacted FH for advice for their own evaluation plans and have used pieces from my plan to guide their own.

Although I was very satisfied with my capstone experience, I wish I had additional time at the outset to learn more about PWUD in FH communities. I believe the evaluation plan could have been stronger with more input from people who access the sites. However, I am hopeful that by including several opportunities for feedback from clients and PWUD within the evaluation, that FH will be able to continue refining the evaluation and their services to meet the needs of these stakeholders.

Having the chance to work on this timely and worthwhile initiative with FH exceeded my expectations for a capstone project. I am looking forward to applying this learning and experience in my future work as a public health practitioner.